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J. M. Sheldon.

TRANSACTIONS

OF THE

Homœopathic Medical Society

OF THE

STATE OF NEW YORK,

FOR THE YEAR 1899.

VOLUME XXXIV.

EDITED BY THE SECRETARY,
JOHN L. MOFFAT B. S., M. D., O. ET A. CH
NEW YORK, (BROOKLYN).

CATALOGUED
NOV 2 1915

"A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics. *All that pertains to the great field of medical learning is his by tradition, by inheritance, by right.*"—*President Eugene H. Porter, M. D., Feb. 1898.*

Ordered published conspicuously in the Transactions every year.—Sept. 22, 1898.

Rochester Democrat and Chronicle Print,
1899.

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OFFICERS, 1898-99.

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*The Censorial Districts embrace the following Counties :

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EASTERN DISTRICT—Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Warren, Washington—19.

MIDDLE DISTRICT—Allegany, Broome, Cattaraugus, Chemung, Chenango, Jefferson, Lewis, Livingston, Madison, Oneida, Oswego, Schuyler, Steuben, Tioga, Tompkins—15.

WESTERN DISTRICT—Cayuga, Chautauqua, Cortland, Erie, Genesee, Monroe, Niagara, Onondaga, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates—14.

OFFICERS 1899-1900.

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L. A. MARTIN,	Binghamton, (M.)	A. WORRALL PALMER,	New York, (S.)

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To Serve Until 1900.

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JAMES WILLIS CANDEE, Syracuse, *Secretary,* - - Anatomy.
JOHN MALLORY LEE, Rochester, - - - - Surgery.

To Serve Until 1901.

ANDREW R. WRIGHT, Buffalo,	Physiology and Hygiene.
FRANK F. LAIRD, Utica,	Obstetrics.

To Serve Until 1902.

WILLIAM MORRIS BUTLER, New York,	Therapeutics.
WILLIAM B. GIFFORD, Attica,	Chemistry.

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E. HASBROUCK,	369 Ninth St., New York, (Bkn.)
CHARLES MCDOWELL,	115 W. 13th St., New York, (Mhn.)
J. T. GREENLEAF,	Owego.
E. W. BRYAN,	Corning.

DELEGATES TO THE INTERSTATE COMMITTEE OF THE AMERICAN INSTITUTE OF HOMŒOPATHY.

J. M. LEE,	*To Serve Until 1900.*
E. H. PORTER,	*To Serve Until 1902.*

COMMITTEE ON LEGISLATION.

E. H. PORTER, *Chairman.*	ASA S. COUCH,	J. M. LEE,
A. B. NORTON,	*C. E. JONES,	J. W. CANDEE,
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BUKK G. CARLETON,	D. G. WILCOX,	E. H. NOBLE,
SHIRLEY R. SNOW,	A. B. VAN LOON.	

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W. H. PROCTOR,	Gynæcology.
H. A. CHURCH,	Laryngology and Rhinology.
GORDON W. HOYT,	Materia Medica.
DANIEL H. ARTHUR,	Neurology.
G. T. MOSELEY,	Obstetrics.
W. E. DEUEL,	Ophthalmology and Otology.
W. I. PIERCE,	Pædiatrics.
J. W. LESEUR,	Public Health.
N. M. COLLINS,	Surgery.

PROCEEDINGS

OF THE

Forty-Seventh* Annual Meeting, Albany, Wednesday, February 15th, 1899.†

The most severe snow storm since "the blizzard" of March, 1888, blocked every railroad in the State on Tuesday, but a few members persisted and reached Albany so that a session was held on Wednesday, February 15, 1899. The New York contingent was delayed until Wednesday noon, although some had started on Monday afternoon.

Vice-President D. G. WILCOX called the meeting to order in the Common Council Chamber, City Hall, at 10 a. m. FRED D. LEWIS was elected Secretary, pro tem., and the Chair appointed:

Committee on Attendance.—W. L. Hartman and G. E. Gorham.
Auditors.—J. W. Sheldon and A. R. Wright.
President's Address—F. W. Adriance and F. Park Lewis.

In the absence of the Secretary the minutes were dispensed with. (See Note.)

THE REPORT OF THE COMMITTEE ON ATTENDANCE

enrolled the following 30:

Albany County—E. G. Cox, G. E. Gorham, C. E. Jones, G. E. Noble, A. B. Van Loon.—5.
Chemung County—F. W. Adriance.
Erie County—G. F. Adams, F. D. Lewis, F. Park Lewis, D. G. Wilcox, A. R. Wright.—5.
Kings County—W. M. Butler, John L. Moffat, H. D. Schenck—3.
Monroe County—R. A. Adams, M. E. Graham, J. M. Lee.—3.
Montgomery County—L. A. Frazier.
New York County—Chas. Deady, J. B. Garrison, A. B. Norton, E. H. Porter.—4.
Onondaga County—J. W. Candee, H. A. Church, W. L. Hartman, J. W. Sheldon.—4.
St. Lawrence County—F. F. Williams.
Saratoga County—E. F. M. Ayres.
Steuben County—A. H. Rodgers.
Wyoming County—W. B. Gifford.

*See correction, pp. 7 and 127, Transactions, 1898.
†Reported by Fred. D. Lewis and John L. Moffat.
NOTE.—The Transactions for 1898 were published Feb. 9th, distributed Feb. 15th.

THE REPORT OF THE BOARD OF CENSORS

recommended the following *22*, all of whom were elected Permanent Members:

	ENDORSERS.
R. A. ADAMS, Rochester, III,* 1868, -	E. G. Cox, J. M. Lee.
EMMA T. P. ALLEN, Brooklyn, II, 1892, -	J. v. H. Baker, M. Belle Brown.
HERBERT C. ALLEN, Brooklyn, I, 1896,	John L. Moffat, E. G. Cox.
E. F. M. AYRES, Saratoga, II, - -	W. S. Pearsall, E. G. Cox.
HERBERT BEALS, Buffalo, I, 1878, - -	J. B. Garrison, E. G. Cox.
WILLIAM C. BRYANT, Brooklyn, I, 1871,	W. M. Butler, J. L. Moffat.
W. TAYLOR CHAMBERLIN, Brooklyn, III, '98,	W. M. Butler, John L. Moffat.
FANNY DONOVAN-CONKLIN, New Brighton, II, 1876, - - - - - - -	F. H. Boynton, A. B. Norton.
HOWARD PERCY DEADY, Liberty, I, 1897,	Chas. Deady, E. G. Cox.
L. W. DEAN, Waterville, I, 1890, - -	A. B. Norton, J. B. Garrison.
R. N. DENISON, Brooklyn, I, 1878, -	A. B. Norton, John L. Moffat.
STUART J. FAIRBANK, Deansboro, III, 1898,	D. G. Wilcox, W. B. Gifford.
CHARLES A. GWYNN, Auburn, I, 1888, -	John L. Moffat. E. G. Cox.
JOSEPH HASBROUCK, Dobbs Ferry, VII, 1869,	C. H. Helfrich, A. B. Norton.
EMILY L. HILL, Gloversville, IV, 1894,	W. S. Garnsey, C. B. Walrad.
JOHN W. HODGE, Niagara Falls, I, 1881,	D. G. Wilcox, W. B. Gifford.
EPHRAIM D. KLOTS, Manhattan, VI, 1894,	J. B. Garrison, A. B. Norton.
A. WORRALL PALMER, Manhattan, I, 1883,	Chas. Deady, W. E. Rounds.
JOSEPH RIEGER, Dunkirk, V, 1893, -	D. G. Wilcox, W. B. Gifford.
EDWIN D. SIMPSON, Manhattan, VI, 1874,	Malcolm Leal, Chas. Deady.
SAMUEL TALMAGE, Brooklyn, VII, 1870, -	John L. Moffat, E. G. Cox.
STANLEY VINCENT, Catskill, I, 1879, -	A. B. Norton, E. G. Cox.

TREASURER'S REPORT.

Chas. Deady, M. D., Treasurer, in account with Homœopathic Medical Society of the State of New York.

Dr.		
To Balance on hand February 8, 1898	$ 635.50	
" Cash received from members and County Societies	1,472.10	
Total	$2,107.60	
Cr.		
By Cash paid out as per vouchers		$1,312.43
" " on hand to balance, February 14, 1899		795.17
Total	$2,107.60	$2,107.60

Later the Auditors reported the Treasurer's accounts correct.

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

FRED D. LEWIS, Chairman, presented three papers:

"Nasal Catarrh in Children," by HERBERT A. CHURCH.

---

*I New York Homœopathic Medical College and Hospital.
II New York Medical College and Hospital for Women.
III Hahnemann of Philadelphia.
IV Hahnemann of Chicago.
V Chicago Homœopathic Medical College.
VI College of Physicians and Surgeons, New York.
VII University of the City of New York, Medical Department.

"The Interdependence of the Diseases of the Throat and Nose and those of the General System," by A. WORRALL PALMER.

"Diseased Tonsil and Its Treatment," by CHAS. E. TEETS.

BUREAU OF PÆDIATRICS.

G. E. GORHAM, in charge, read:

"Cases Illustrating the Importance of the Early Recognition of Pulmonary Invasion," by W. W. VAN BAUN, of Philadelphia.

"The Indicated Remedy," by G. E. GORHAM.

BUREAU OF PUBLIC HEALTH.

W. B. GIFFORD, Chairman, submitted three papers:

*"A Peculiar Type of Small Pox" (illustrated), by F. W. ADRIANCE.

*"The Pollution of Public Water Supplies," by W. H. HODGE.

*"Hygiene of Consumption," by BURT J. MAYCOCK.

BUREAU OF CLINICAL MEDICINE.

*"Chronic Seminal Vesiculitis as a Cause of Sexual Disorders in Men," by E. H. NOBLE.

F. PARK LEWIS demonstrated a new instrument, "The Microbioscope," by which the iris may be studied under strong illumination and large amplification.

BUREAU OF SURGERY.

*"Office Treatment of Fistula in Ano," by E. F. HOYT.

BUREAU OF NEUROLOGY.

*"The Psychological Aspects of Grief," by SELDEN H. TALCOTT.

*"A Suggestion in the Treatment of Tremor," by G. F. LAIDLAW.

BUREAU OF OBSTETRICS.

*"Fibroid Degeneration of the Placenta with Malformation of the Fœtus," by W. S. GARNSEY.

*"Puerperal Eclampsia," by E. G. COX.

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

*"A Case of Superficial Degeneration of the Retina," by C. H. HELFRICH.

*"Some of the More Remote Effects of Eye Strain," by G. W. MCDOWELL.

---

*Read by title.

The following officers were elected without contest:

President—JAY W. SHELDON, of Syracuse.
First Vice-President—F. W. ADRIANCE, of Elmira.
Second Vice-President—G. E. GORHAM, of Albany.
Third Vice-President—N. M. COLLINS, of Rochester.
Secretary—JOHN L. MOFFAT, of Brooklyn.
Treasurer—CHARLES DEADY, of Manhattan.
Necrologist—W. S. GARNSEY, of Gloversville.
Counsel—JOHN C. COLEMAN, Esq., of Manhattan.

Censors—M. O. TERRY, Utica, Middle District.
J. E. SLAUGHT, Warsaw, Western District.
H. D. SCHENCK, Brooklyn, Southern District.
C. E. TEETS, Manhattan, Southern District.
L. A. FRAZIER, Amsterdam, Eastern District.
L. A. MARTIN, Binghamton, Middle District.
M. E. GRAHAM, Rochester, Western District.
W. L. HARTMAN, Syracuse, Western District.
D. M. HIBBARD, Olean, Middle District.
FRED. D. LEWIS, Buffalo, Western District.
E. G. COX, Albany, Eastern District.
A. WORRALL PALMER, Manhattan, Southern District.

STATE MEDICAL EXAMINERS.

The Chair announced 27 ballots cast, of which *W. M. BUTLER received 25, JOHN B. GARRISON 20, *W. B. GIFFORD 18, and GEORGE E. GORHAM 15.

No election was held for the committee to nominate for State Medical Examiners.

PRESIDENT NORTON then read excerpts from his Presidential Address:

THE TREND OF THE TIMES.

It seems not inopportune at this time, i. e., the last annual meeting to be held by this Society in the nineteenth century, to review somewhat the history of the past and, judging so far as we can from this history and from The Trend of the Times, forecast the future of homœopathy as we see it.

The history of homœopathy may be said to commence with the birth of Hahnemann on April 10th, 1755. In 1790 we find Hahnemann, eleven years after receiving the title of Doctor of Medicine, dissatisfied with the then existing method of practice, withdrawing

*Later appointed by the Regents.

from the same and depending upon his translations for a living for his growing family. In this year while translating Cullen's Materia Medica his attention was attracted to the therapeutic uses of Peruvian bark and was led to experiment with it upon himself. While the discovery of the law Similia Similibus Curentur thus dates from the year 1790, it was not proclaimed to the world until six years had been expended in the proving of drugs and verifying his principle.

The present year, 1899, is the hundredth anniversary of Hahnemann's discovery of the great value of belladonna in scarlet fever. But like all his other work, instead of the reward this discovery so grandly merited it brought upon him additional persecution and trial. His professional brethren, jealous of his rising fame in the treatment of this disease during a great epidemic, incited the apothecaries of his city to bring an action at law against him for dispensing his own medicine; which being decided against Hahnemann drove him from his home to seek a new field.

The attitude of the medical profession at this time toward Hahnemann, the Martin Luther of homœopathy, can be no better exemplified than by the fact that from the time of his graduation as doctor of medicine to his death, Hahnemann was forced to live in twenty-eight different places. Poor and persecuted, driven from town to town, trial, sorrow, privation, malevolence, falsehood, all followed him like shadows until his death in 1843. In this manner was homœopathy received by the medical fraternity of Europe.

Let us now briefly review the reception of homœopathy in this country and in New York State especially for the last fifty years.

Homœopathy was first introduced into America by Dr. Hans Birch Gram, who settled in New York City in 1825. Dr. Gram, on returning to this country, gave up a lucrative practice in Copenhagen to introduce the new method to the profession under institutions and conditions he deemed more favorable to its general adoption than Europe afforded. "He came away from a city, a people and a country he deeply loved, as an apostle of what he deemed a reform most important to all humanity in all countries, ages and times." The present position of homœopathy in this country emphasizes the soundness of Dr. Gram's judgment, but at what a cost to him cannot be better illustrated than by a quotation from the presidential address before this Society of Dr. Wm. Tod Helmuth, ten years ago to-day. He says: "Professional and social ostracism by the old school was the lot of every homœopathist, and from the more rabid the most odious epithets and insinuations were unsparingly applied."

In the London Lancet for January, 1851, is an article headed "Quackery Rampant", in which appears the following: "The last monstrosity, homœopathy, the most absurd of all, has acquired an importance, temporary as it must be for many reasons, one of the many, we regret to say, which has originated in certain dishonest members of our own profession. These men (homœopathists) unable from their shallow capacities and acquirements to fight fairly and to compete manfully with their brethren, have shrunk, as it were, behind

the hedge and turned assassins to obtain a livelihood. Yet, not content with practising a quackery, the absurdity of which has no parallel in history, these renegades lose no opportunity of placing their daggers in the reputation of legitimate medicine." Enough more of similar vituperation can be collated from the medical journals of that period to form several large volumes, but as President Helmuth's address has so well shown the spirit that animated our old school friends of that time we will hurry on to more recent history to illustrate their present love and esteem.

While New York was the birthplace of homœopathy in this country through Dr. Gram in 1825, a sister State, Pennsylvania, has the honor of having organized the first association of homœopathic physicians in America, which was formed in Philadelphia in 1833 and was composed of both physicians and laymen. New York State was not far behind, for on September 23rd, 1834, the New York Homœopathic Physicians' Society, composed also of physicians and laymen, was organized in New York City. Our own State Society was organized May 15th, 1850, as the Academy of Medicine of the State of New York, the title being changed to our present one in February, 1851.

As next year is therefore our fiftieth birthday, I would recommend that a special committee be appointed to formulate plans for our semi-centennial celebration in 1900.

About this time when laws were enacted by our State Legislature authorizing the formation of homœopathic medical societies, State and county, and homœopathic medical colleges, the opposition on the part of the dominant school was intense. We were ostracised, disfellowshipped and spurned from their doors as contaminating and pestiferous. A few years later as the result of hard, active work, in spite of their strongest opposition, we commenced to secure hospitals, asylums and institutions. The Hahnemann Hospital of New York opened in 1869, the Brooklyn Homœopathic Hospital in 1871, the Middletown State Homœopathic Hospital in 1874, the Ward's Island Hospital in 1875, and so on from year to year.

A few years later open, active hostility to our school ceased, and in 1882 we find our old school friends in the New York County and State Medical societies stirring up a tempest in a teapot over their code of ethics, with the result that a few of the old timers bolted their State organization, forming new associations of their own, and now the self-styled "regular school" in this State is made up of two factions, the New Coders, those supporting their legally organized State Society, and what might be termed the irregulars or bolters, or as more frequently called, the old coders.

While there has not been for the last twenty years the bitter animosities and insults to our school that in former years had been cast upon us, yet that our old school friends have met with any real change of heart, I do not believe to be borne out by any impartial examination of the facts.

The five years' fight, from 1885 to 1890, which finally resulted in the passage of our bill providing for three state boards of medical exam-

iners was a long and hard one. The old school endeavored, year after year, to secure the passage of an act giving them in a one-board bill absolute control of the licensing in the future of all physicians. Our bill for three boards was received as follows: The committee on legislation of the New York State Medical Society reporting this bill in February, 1890, said, "This is ridiculous on its face." The Medical Record, in an editorial April 20th, 1890, says: "The creation of three distinct examining boards is a clumsy, unnecessary, expensive and pernicious contrivance." But in spite of all their opposition our bill became a law which we are glad to say is now working satisfactorily to all schools. The more recent important legislative work, such as securing our asylum at Collins and the defeat of the dispensary bill, are so familiar to you all that they will not be dwelt upon now.

As still further illustrating the present attitude of "our friends the enemy" a few quotations from the more recent current literature may prove both interesting and instructive.

In the anniversary address before the New York State Medical Society, February, 1895, upon "Credulity and Skepticism in Medicine," the President, Dr. George Henry Fox, refers to our school in the following words: "Delusions such as homœopathy, with its sugar-coated expectancy," etc. One year ago Dr. Seneca D. Powell, President of the New York State Medical Society, in his anniversary address, January 26th, 1898, gave utterance to the following remarkable statement: "Now, since this is the legally instituted and recognized medical society of the State of New York, and the body in which inheres the major responsibility for whatever action may be taken affecting medical affairs, it follows that all legislation relating to the practice of medicine, either as between physicians or between the physician and the community, should originate in this Society and be under the control and administration of this Society." We would remind the learned doctor that there are other equally legally instituted and recognized medical societies in the State of New York which cannot and will not be ignored in medical legislation.

At the same meeting, January, 1898, the following utterance, was made upon the floor without a single voice being raised in protest: "It was notorious that judges selected their physicians from the ranks of the homœopaths or the quacks, and it was the exception for a judge to have in his employ a reputable, distinguished physician."—The Medical News, February 26, 1898.

An editorial note in the British Medical Journal, May 7th, 1898, upon Quackery in Germany reads "of the special lines of quackery, the most numerously represented was 'Nature healing,' which was professed by 220 persons; then came sympathy with 160 exponents, homœopathy with 97, massage with 72, magnetism with 46, and tapeworm curing with 19."

The Medical News, May 28th, 1898, contains a Philadelphia letter in which the following reference is made to the action of the Homœopathic Medical Society regarding appointments of members of our school in the United States Army and Navy service: "It will

be amusing to follow the proceedings which are booked to develop along the lines of homœopathic agitation; the anti-vaccinationists and anti-vivisectionists have had their fling at the public, the faith-curers are many of them in jail, and it is but fair to give these other agitators their chance. The public must be amused."

During the past year a series of letters have appeared in the London Lancet, the consensus being that no so-called "regulars" should consult with homœopaths, and one society at least has by resolution reaffirmed that none of their members should do so. Many more similar quotations could be found in almost every month's addition to allopathic literature, but time forbids their presentation here.

Within the year, Dr. Charles F. Adams, Assistant Surgeon in the New Jersey National Guard, after passing a better examination both medical and physical than any other candidate before the board of old school medical examiners was not recommended for appointment to the volunteer service of the United States Army as was acknowledged by the board, who could not reject him on other grounds, because he was a homœopath. An appeal was made by Dr. Adam's friends to the Governor, who would not permit this medical bigotry, and a vacancy being at hand appointed him for merit, over the heads of the examining board, to the higher office of surgeon with the rank of major. Another of our candidates in Washington after passing the examination was rejected as soon as it was learned that he was a homœopath, because he was not an immune.

Other examples of their friendship for us and liberality toward our school may be seen in their requirement that all who are in fellowship with us yet who may desire to become affiliated with their societies, must first withdraw from the homœopathic associations. Homœopathic physicians are also refused appointments as life insurance examiners in many companies, presumably through objections by their old school medical examiners.

My own personal experience in two instances within the past year may also be interesting and point a moral. Last spring I made an application for life insurance in the Prudential Insurance Company of America contingent upon their appointing homœopathic examiners in the City of New York, which, after considerable pressure had been brought to bear upon the company, I was informed would be done. Later I learned that, presumably through the opposition of their old school medical examiner, homœopaths would not be appointed.

Through friendship for the agent of this company, who had done all that he could to secure the appointment of homœopaths, and as I wanted more insurance without delay, I allowed my application to be presented. My examination was perfectly satisfactory to the general examiner, but when it came to their head medical examiner, who presumably had been made some trouble by my demand that his company should appoint some homœopathic physician as examiner, I learned that I was to be rejected. I immediately withdrew my application for insurance in that company, took the same examination papers to the Mutual Life Insurance Company of New York, stated

the facts and was assured that if I could pass the same examination before their examiner a policy would be granted. This was immediately done and a policy issued to me by this company. I believe my intended rejection by the Prudential Insurance Company was owing to the bigotry and spite of their old school medical examiner.

The other instance was that of a patient with a very rare and interesting tumor of the eye which I referred to a very prominent old school oculist for examination and diagnosis. After each of the first two examinations, for which the patient was charged a larger fee than he could afford to pay, the consulting oculist wrote me his opinion in a long and very courteous letter. Six months later the case having materially changed I asked the father of the child to again take her to the doctor for another examination. He replied that he could not do so so he had no money to pay him for it. I then wrote a note to the doctor reminding him of the case, stating that he had been paid for each of his previous examinations, while I had received nothing for six months' treatment of the case; that the father had now no money to pay for his examination and asked him as a favor to me to see the child this time gratuitously. The father of the child returned later and reported that the doctor after reading my letter was very indignant, stated that I had no business to ask him to see the case for nothing and at first refused to do so, but later barely glanced at the eye and told the father to bring the child to his hospital for operation and has this time not written me one word in reference to the case. Here then is an instance where one of New York's most prominent old school oculists was perfectly willing to consult with me as long as the patient was able to pay his fee, but when he had no more money refused to do so and tried to steal the case because an interesting one. Does this physician treat the members of his own school in this unprofessional and scurrilous manner? I believe not.

The quotation taken from the address of the President of the old school state society one year ago, in which he arrogates to their school of medicine the sole right to govern medical matters in this State, I believe exactly illustrates their present attitude toward homœopathy, i. e., they forget or willfully ignore the fact that there are others equally interested, and attempt to control all matters relating to the medical profession from their point of view without consultation with the others.

In support of this opinion look at recent legislative history. Were they willing to confer with us and accept what they now admit is an excellent and equable law providing for three boards of medical examiners? No, they worked day and night to pass their one-board bill giving to them full control of the licensing power in the State. Did they favor our just claim for a second State asylum for the insane when Middletown could not begin to hold all desiring homœopathic treatment? No, they opposed our request for appropriations on every occasion. Did they support our bill for expert testimony, which was formulated after many consultations between representatives of the medical and legal professions, to which they were invited and repre-

sented? No, they even had the assurance to ask us to drop our bill and accept theirs. In the effort last year to correct the abuse of medical charities did they invite us to confer with them in the formation of a bill? Again no; they drew up their own bill placing the power to control all of our dispensaries in a board inimical to our school and when they found they could not pass the same without our support, then came and offered to amend in any way we desired.

Judging them from their actions and their public utterances, I for one cannot see any change of heart, so far as the rank and file are concerned, from fifty years ago. I wish to except from this charge of medical bigotry quite a number of the leaders or more representative men of their school, but I firmly believe what is here said honestly applies to the large mass of our old school brethren. To be sure the hostility is not as open and bitter as formerly; but may not that be accounted for by a wholesome respect for our strength and power? I can see no signs of their voluntarily consulting with us in medical matters affecting either the public or the profession, and in regard to public positions and offices I believe it to be their policy to ignore the rights of our school, to claim and strive to secure all such positions for themselves, only yielding what they are compelled to do. If this is so does it represent the brotherly love and harmony that should exist between two branches of a learned profession?

The statement that is so generally made "that the two schools of medicine are every day coming nearer together" I do not believe to be true. I will admit that on the surface this may apparently be so, but with the exception of the acts of a few I can find no evidence pointing in this direction, while on the contrary the evidence seems to point to the same spirit of antagonism as ever existing beneath the surface.

Thirty-five years ago the late Dr. Carroll Dunham, in an address before this Society stated the relation that then existed between the two schools of medicine so well, and in words that I believe still are true, that I shall quote them here. He says: "Now, as in the days of Hahnemann, there is an antagonism between homœopathists and the old school. The former hold out to the latter, what they believe to be that method which has ever been a desiratum in medicine. The latter refuse even to examine it, and expel the homœopathists from all associations over which they hold control. We cannot unite with them in any associated labors without ignoring and disavowing what we believe to be the theory and practice of the all-important part of medical science—the science of therapeutics. They will not unite with us in associated labors for the development of this science."

In my opinion the banner of similia must continue to wave until the barriers are all broken down. The fight for just recognition will go on until the doors of the army and navy and all public institutions are open to our graduates; until membership in their societies is granted to every practitioner of medicine together with the free discussion of the treatment of disease without a question as to his school of graduation; and until a chair of homœopathic therapeutics, filled

by a homœopath, is established in their colleges and certificates of attendance in homœopathic colleges are accepted in their colleges on the same basis as are those of their own faith. Then and not until then will schools of medicine cease to exist and the medical profession live in love and harmony. I regret to say that this utopian period seems to me as far distant as ever.

Turning now to other matters let me for a moment refer to the medical department of our army and navy. The glorious victories won on land and sea by our American soldiers and sailors are only tarnished by incompetency and red-tapeism in two departments of the service, i. e., the quartermaster's department and the medical service. The disgrace brought upon this country through these departments cannot be wiped out or forgotten by the memory of the grand work of our boys at Manila and Santiago. The press throughout the country has sufficiently exploited the criminal errors in these departments. Every one knows them, even to the whitewashing committee, but nothing can now be done to restore life to a single one of our brave soldiers whose death is directly chargeable to the Surgeon General's Department.

What right had the surgeon general to expect that army surgeons, with no experience in the management of large hospitals, could at once assume the full charge of the conduction of the same? I am informed that he had the power to place contract surgeons, of experience in hospital work (any number of whom could be found) in full control of the medical service, certainly if he had not the Commander-in-Chief could have done so. Any physician of any school having hospital experience, if given the power, could have immediately brought order out of chaos and saved the lives of thousands of our most patriotic citizens. But instead these lives were sacrificed on the altar of self-conceit and arrogance so notorious in the army service. These blunders, however, will result in better service in the future, for practical drilling will undoubtedly be enforced in these departments hereafter.

During the past year there have appeared in our own journals and societies much agitation as to the relation of our school of medicine to the medical department of the army and navy, and in some cases hasty and ill-conceived action on the part of individual members and societies has brought discredit upon our school rather than advantage. It has been generally assumed and often stated that members of our school have been debarred from appointment in the medical service of the regular army. I believe that we would be so debarred if within the power of the medical examining board; but have we any proof that we have been debarred on account of our school? As we have therefore no evidence that homœopathic graduates have ever been refused appointment because of their faith, let us first endeavor by special education and inducements to get our young men particularly well fitted and willing to stand for such examinations. If then rejected because of their school we can go to Congress and demand recognition. But, so long as the answer is given, as it was

to the delegates of one of our Societies, that the law makes no discrimination, and the query is then raised, have you any evidence of such discrimination, it places our schools in the attitude of complaining when we have no grievance. Our present laws provide that "No appointments are made in the regular army except after an examination by an army medical examining board, and all applicants must be graduates in medicine and less than 29 years of age."

I would suggest, therefore, the propriety of this Society adopting a resolution recommending that the Homœopathic College of New York be requested to establish a chair of military surgery and hygiene which shall teach all the requirements of the medical and surgical service in the army and navy; and, that this recommendation be referred to the American Institute of Homœopathy for adoption by all the colleges having fellowship in that body.

In regard to the abuse of medical charities I would call your attention to the bill now before our State Legislature providing for the appointment of a board of control to consist of twelve members, six of whom shall be members of the three legally recognized State Medical Societies and six non-medical members who shall be directors of some dispensary within the State, the nomination of the members of this board to be made equally by the three State Medical Societies on the same plan as we now nominate for medical examiners. This bill was drafted by a committee of this Society in conference with similar committees from the New York State Medical Society, the New York State Eclectic Medical Society and from the organization of dispensary managers. Under this bill, which will be presented to you by your special committee on dispensaries, the rights of our school have been carefully guarded and protected. I would, therefore, recommend the adoption of a resolution endorsing this bill.

One year ago I offered an amendment to our constitution providing for but one meeting of the Society each year in place of the two we now hold. My suggestion would be to hold one session of from two to three days once a year, preferably in September or October instead of the present method of two sessions of a day and a half each.

It has been the general idea of many that we were obliged to hold one meeting in Albany and in February. Our right to make this change is provided for in the laws of 1875, Chap. 449, which says: "This Society may select the time and place for holding its annual and other meetings." Another prevalent idea is that it is expedient to hold one meeting in Albany during the session of the Legislature. This, I believe, to be a mistake because our annual meeting is always poorly attended and the impression as to the strength of our school when but 20 to 50 are present at our annual meeting I believe to be harmful rather than beneficial.

Our legislative work is all carried on through our Committee on Legislation to the entire satisfaction, I am sure, of every member of the Society, and I do not recall a single instance when the fact of our being in session in Albany has in any way strengthened or aided the work of this committee.

In this connection I wish to pay a most deserved compliment to Dr. J. M. Lee, whose work as Chairman of our Legislative Committee for the last five years has accomplished so much for our school of medicine in this State; the heartiness and thoroughness with which he has entered into this work, and at so much personal sacrifice of both time and money, places his name on our scroll of honor by the side of our other indefatigable legislative worker for homœopathy, Dr. Horace M. Paine.

These are the only arguments I have ever heard offered for holding an annual meeting in February. A few of the arguments in favor of my amendment providing for but one meeting and that to be held in the fall, are: First, the interest of our members in the meetings is far greater, as demonstrated at our Syracuse meeting, when there is a larger attendance than when but few are present. Second, members would spend more time and care in the preparation and discussion of papers to be presented before a large audience than a small one and in this way the character of our meetings will be better. Third, the social feature of our Society, which by the way is a very important item in the success of an organization, could be greatly enhanced in a three days' session in the fall. Fourth, one large, successful meeting with from one to two hundred in attendance would impress the public with the strength of our school far better than two meetings with one-half the attendance. Fifth, the annual meeting in midwinter occurs at a time when we are all more busy, and those who do attend do so with more difficulty and with a greater sacrifice. Sixth, the item of expense; one meeting a year would be a decided economy to the Society and to the members as well, for at one meeting there would be a saving in traveling and hotel expenses, and with a larger attendance we would secure a reduction in both hotel and railroad rates. Lastly, the success of some of our sister societies that hold but one meeting a year all emphasize to me the wisdom of trying a change. I would, therefore, recommend the adoption of the proposed amendment providing for but one meeting each year.

Another suggestion that seems to me timely is in regard to our delegate members, and I would recommend that amendments be offered to our Constitution and By-Laws providing for the doing away with all delegate members. This suggestion is offered for the following reasons: First, we provide for delegates from corporate institutions or associations within the State and as no such institutions or associations have sent such delegates for a number of years, if ever, this feature is unnecessary and should be done away with. Second, as to delegates from county societies; there are but 15 counties out of 58 sending delegates and considerably over one-half of all the money received from these societies is paid by two. I believe it an injustice that these 15 counties should be asked to pay a tax to this Society that the 43 other counties do not pay, and particularly that two counties should pay a greater tax to this Society than all the rest of the State put together. This money, in my opinion, can be better expended, and for greater good to the cause, by these

county societies in strengthening their local organization. I believe that this Society, with over 400 active members and with the new members that will come in as soon as they cease to have their dues paid by their county society, can meet all of its expenses. I understand that the Treasurer agrees with me in this statement.

In closing I wish to congratulate the Society on what, judging from its recent attendance and interest, appears to be the dawn of a new era in an always active and progressive organization, and to again extend to this Society my deep appreciation of the high honor conferred in selecting me to fill the Chair occupied by so many illustrious predecessors.

On motion, it was voted that the President appoint a "Jubilee Committee" of twenty-five, with power to add to their number and to make all arrangements for our jubilee meeting in 1900. Voted to add A. B. Norton to that committee.

The Chair appointed: W. M. Butler, Chairman, Jennie v. H. Baker, E. Chapin, E. Rodney Fiske, H. J. Pierron, H. D. Schenck, R. K. Valentine, A. G. Warner, M. Belle Brown, Chas. Deady, H. M. Dearborn, F. E. Doughty, J. B. Garrison, A. B. Norton, G. W. Roberts, D. J. Roberts, J. W. Candee, J. W. Sheldon, W. S. Garnsey, C. E. Jones, J. M. Lee, F. Park Lewis, DeWitt G. Wilcox, A. R. Wright, E. E. Snyder, and Selden H. Talcott.

On motion the following resolutions were unanimously adopted:

Resolved, We request the New York Homœopathic Medical College and Hospital to establish a chair of Military Surgery and Hygiene which shall teach all the requirements of medical and surgical service in the army and navy; and

Resolved, We recommend the American Institute of Homœopathy to urge upon each college in affiliation with it the establishment of a chair of Military Surgery and Hygiene which shall teach all the requirements of medical and surgical service in the army and navy.

A. B. NORTON gave notice of amendment to the Constitution and By-Laws to abolish delegate membership: Art. II of the Constitution and By-Laws I, §3, §4, II, §1, §3, III, §1, VI, §3.

The Secretary gave notice of amending By-Law II, §2, changing the form of application by specification of the license under which the applicant is practising, and, further, a promise to return the certificate of membership upon resignation or being dropped from membership.

REPORT OF THE EXECUTIVE BOARD.

This Board has held three meetings and considered the connection of Drs. Little and Wallace with the Bemis Sanitarium, which matter, although no names were mentioned, was meant by the remarks of

Drs. Paine and Birdsall last February.* After careful investigation we are satisfied that Dr. Little is violating the code of ethics (Dr. Wallace is no longer connected with Bemis), but feel that a matter of so much importance to those concerned should be prosecuted strictly according to prescribed forms, and only after written charges shall have been preferred to the Society.

W. C. Latimer was reinstated under standing resolution of February 9, 1892.

JOHN L. MOFFAT, Clerk.

REPORT OF THE LEGISLATIVE COMMITTEE.

Your Legislative Committee would respectfully report that there are a dozen bills in the Legislature which require considerable attention. We are working harmoniously and unitedly with similar committees of the two other schools of medicine and there is no reason why we should not pass or defeat every bill which either advances or curtails the interests of the medical profession.

With the exception of one year, your Chairman has served in this capacity since 1893. He has been most ably and faithfully supported by his associates on the Committee and the members of the profession throughout the State. By this harmonious action of the school, not a single bill of any consequence has failed to pass and on the other hand, we have defeated every objectionable measure which has come before the Legislature.

Our chiefest triumph has been in the establishment of the Collins State Homœopathic Hospital for the Insane in Erie County, which now has property valued at from between three and four hundred thousand dollars and 110 patients under treatment.

For several weeks during each year of the legislative session the work has been arduous and a severe tax upon the time and strength of the Committee. Not infrequently have we been obliged to remain at our desks until two o'clock in the morning, especially on Saturday, in order that our wishes might be made known to the leaders in the Legislature on Monday morning.

This will be my last year as Chairman and I desire to most heartily thank every member of the Legislative Committee for his hearty support and co-operation.

J. M. LEE,
E. H. PORTER,
W. M. BUTLER,
F. PARK LEWIS,
J. W. SHELDON,
ASA S. COUCH,
E. G. COX,
C. E. JONES,
GEO. M. DILLOW.

J. M. LEE presented his bill for $140.93 necessary expenses of the Legislative Committee. On motion, it was ordered paid.

Transactions, 1898, p. 36.

On motion of W. M. BUTLER, the following was unanimously voted:

Whereas, Under the authority given by §1226, Chap. 378, Laws of 1897, of this State, New York City, through its Board of Health, is engaged in the business of selling antitoxin in different cities of the United States, and

Whereas, We believe it to be contrary to the spirit of our institutions and outside the province of municipalities, in the discharge of their legitimate functions, to engage in commercial ventures and to compete with their own citizens engaged in the same line of business, now therefore be it

Resolved by this Society, That we favor the immediate passage of the Collier bill, now pending before the Assembly, which has for its object the repeal of said section 1226.

The resignations of CHARLES A. BROWN, F. P. JENKS, G. W. LITTLE and W. I. WALLACE were presented and accepted.

EGBERT GUERNSEY was elected a Senior Member, upon nomination by John L. Moffat; A. B. SOUTHWICK, upon nomination by Charles Deady, was elected a Senior Member to date from 1898.

JOHN L. MOFFAT: I wish to nominate for Honorary Membership Drs. WILLIAM B. VAN LENNEP, of Philadelphia; NATHANIEL W. EMERSON, of Boston, and GEORGE F. SHEARS, of Chicago; not because they accepted invitations and read papers before this Society, but because each is a surgeon of pre-eminence, whose work for the advancement of surgery sheds lustre upon our school and augments the repute of American surgery.

REPORT OF COMMITTEE ON INCREASING MEMBERSHIP.

The Committee on New Members would report that they have done their best by personal appeal and correspondence to add to the membership of the Society, and through these efforts thirty-six new members have been gained. The chief obstacle met in New York and Kings Counties has been the large number of delegate members, who on this account refuse to become permanent members.

Respectfully submitted,

WILLIAM MORRIS BUTLER, Chairman.

A. B. NORTON'S proposed amendment to the Constitution and By-Laws, providing that there shall be but one regular meeting each year and that in the fall, was brought before the house and elicited brief discussion.

J. M. LEE: My experience convinces me that it is essential for this Society to meet in Albany during the session of the Legislature.

The amendment was put to vote and lost.

DR. NORTON gave notice that he would propose the same amendment next February.

There were no reports from the Committee on Life Insurance Companies, the State Legislative League, the Necrologist, the Committee on Abuse of Medical Charity, the Committee on Expert Testimony, or the Delegates to Institute Interstate Committee.

The following bureaus made no report: Obstetrics, Gynæcology, Ophthalmology and Materia Medica.

REPORT OF COMMITTEE ON MARKINGS BY STATE MEDICAL EXAMINERS.

The complaint that homœopathic candidates for licenses stand notoriously lower in chemistry than do the allopaths—that chemistry is our weak point*—naturally invites the question, "Is this because the homœopathic examiner is more rigid in his markings? Or are our men more ignorant of the subject?"

Obviously the first thing to do was to compare the papers on file at Albany. This your committee did on November 14, 1898, to an extent sufficient to satisfy us that the discrepancies below noted may be attributed to "personal equation" and to the fact that the markings were made by different men each ignorant of the other's work. There is certainly no ground for any statement that our examiner was unduly critical in his markings.

The general impression left in our minds from looking over the papers is that the homœopathists' replies were on the average rather inferior to those of the allopathists.

The notes of our examination show:

3, "Similar Answers Marked Alike."

1, "Similar Answers Marked Unlike."†

Of 5 "Unlike Answers Marked Alike" the homœopathic answer was (according to our judgment) inferior to the allopathic in six instances, and superior in two.‡ In three instances this discrepancy was heightened by the homœopathic inferior answer being marked the higher.

As an instance we have deemed it wise to copy the answers to one of these questions.

Question 4 in chemistry, New York, May 18, 1898: "State the normal reaction of urine. How is the reaction noted? To what is it due?"

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*See Transactions, 1897, pp. 26, 28.

†May, '98—H. 765, 7, marked 90; S. 731, 7, marked 6.

‡May, '98—H. 764, 3, marked 90; inferior to S. 735, 3, marked 8.
H. 764, 6, marked 100; inferior to S. 735, 6, marked 8.
June, '98—H. 212, marked 100; inferior to S. 112, marked 9.
May, '98—H. 764, 8, marked 100; inferior to S. 735, 8, marked 10.
H. 696, 2, marked 90; inferior to S. 729, 2, marked 9.
H. 696, 4, marked 100; inferior to S. 729, 4, marked 10.
H. 753, 1, marked 100; superior to S. 731, 1, marked 10.
H. 766, 5, marked 100; superior to S. 745, 5, marked 10.

H. 696 replied: "Slightly acid. Litmus paper. Power of acids turning vegetable blues red." Marked 100.

S. 729 wrote: "The normal reaction of urine is acid. The reaction is noted by immersing a piece of paper, moistened with blue litmus, into the urine, which immediately becomes red. The acid reaction is due to the presence of acid sodium urate, acid potassium urate and acid sodium phosphate." Marked 10.

Our homœopathist may have misapprehended the question, but as a matter of fact he did not give a perfect answer.

Ten homœopathic and ten allopathic papers were taken from each of three examinations in chemistry June, '97, and May and June, '98, and carefully compared in consultation, without noting the names of the candidates. The eclectic papers were too few in number and so different in quality that we gave up the attempt to include them in our comparison.

JOHN L. MOFFAT,
GEORGE E. GORHAM,
CHARLES E. JONES,
A. B. VAN LOON,
Committee.

On motion the selection of the time and place of the next semi-annual meeting was referred to the Executive Board with power.

Adjourned.

JOHN L. MOFFAT, Secretary.

REPORT

OF THE

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

"Nasal Catarrh in Children," - - - HERBERT A. CHURCH.
"The Interdependence of the Diseases of the Throat and Nose and those of the General System," - - A. WORRALL PALMER.
"Diseased Tonsil and Its Treatment," - - - CHAS. E. TEETS.

NASAL CATARRH IN CHILDREN.

HERBERT A. CHURCH, M. D.,
SYRACUSE.

Nothing gives more trouble to the general practitioner than to know what to do for nasal catarrh in children; and nothing is more unsatisfactory than the treatment generally prescribed for what is commonly termed "Catarrh." Many cases are incorrectly diagnosed from the fact that many physicians have not the necessary apparatus for making a complete examination, as few physicians in general practice have the required instruments. It is with this idea in view that I am calling your attention to this very common symptom, for in nearly every case it is a symptom of some local or constitutional trouble, except some times in the acute variety or epidemic form, and might then be considered as a disease in itself.

Nasal catarrh may be classified as acute, chronic, hypertrophic and atrophic.

Acute catarrhal rhinitis is of frequent occurrence in children and may be due to climatic conditions, local irritants as dust, smoke, etc., or a deviation of the septum, exostosis or adenoid vegetations which induce a recurrence of these attacks.

Hypertrophic rhinitis is more often found among the better class and well nourished children, but not of as frequent occurrence as the atrophic form in young children, probably due in part to the lack of development of erectile tissue. Hypertrophic rhinitis is the result many times of repeated attacks of acute rhinitis, resulting in a chronic hypertrophy and structural changes in the mucous membrane. The hypertrophy is not uniform and is more pronounced on the free surfaces or lower borders of the middle and inferior turbinated bones.

Exostoses and deflections of the septum, or any growth which may impede the circulation, tend to produce this condition of tumefaction and thickening of the mucous membrane. When long existing, the hypertrophies become organized with an increased blood supply. Often irritants, as snuffs and astringents, aggravate this condition, also dust or any irritant which may enter the nasal passages.

The most prominent symptoms are difficulty in breathing due to the hypertrophies and mucous secretions which are very tenacious. Often the patient is compelled to breathe entirely through the mouth owing to the occlusions. Frequently frontal headaches occur, due to the closure of the frontal sinuses. Sometimes we will have tinnitus with some deafness. Dropping of mucus in the throat and larynx causes hoarseness, and sometimes produces a croupy condition. Sometimes in young children, where the breathing space is very narrow, the mucus is not expelled and remains as an irritant. Fortunately, as I have said before, hypertrophic rhinitis is not of very frequent occurrence in young children.

Atrophic rhinitis is sometimes a sequela of hypertrophic rhinitis, although many times it is due to a general atrophic condition of the nose, as in cases of mouth breathers, when from lack of use the nose is arrested in the development and atrophy of the mucous membrane and underlying structures result. The glands and cells undergo a fatty degeneration, and the mucous membranes secrete a viscid mucus which dries and scabs, which when removed leaves a cracked and bleeding surface. The odor is very offensive when in this advanced stage the deeper structures are involved.

These conditions are seen in ill-nourished children, especially among the poorer classes. I think in the majority of cases of atrophic rhinitis we will find associated with it hypertrophy of the pharyngeal tonsil to a greater or less degree. Of all catarrhal conditions in children under the age of puberty, we may safely say that 75 per cent. are due to hypertrophy of the pharyngeal tonsil, the remainder are due to some other local cause, as deflection of the septum, spurs, etc., or constitutional derangements, as in cases of scrofulous, syphilitic, or tubercular diathesis.

My object in writing this paper has been to call your attention to certain conditions which are so common they are often overlooked or disregarded, when many times they are the symptoms of a condition which may lead to grave results, as in adenoid cases where many times the symptoms are simply catarrhal, but are the existing cause of otitis media or mastoiditis. Neither did I intend to give you a lengthy dissertation on the symptoms of rhinitis in all its forms, as they are familiar to you all.

What I wish to emphasize most is, that we make a careful diagnosis in each and every case, that we may be more successful in the treatment. If due to adenoids, remove them and use the indicated remedy for the constitutional conditions in which adenoids occur, and not wait for the remedy to cure the case, for it will not do it. Do not wait for the ear complications which almost always follow the hypertrophy of

the pharyngeal tonsil. If due to local causes as deflections, spurs, etc., remove the existing cause. If in young children where the mucus is not expelled from a very narrow nose and remains as an irritant, cleanse the nose, perhaps using a normal salt solution or plain albolene or whatever may be indicated. I do not believe, as a rule, watery solutions are beneficial to the nose, but you may use an oily solution in any case without harm.

Nasal catarrh in children should receive greater attention than it has in the past, and should not be considered as comparatively unimportant, as it is many times an indication of a condition which has far reaching results.

THE INTERDEPENDENCE OF THE DISEASES OF THE THROAT AND NOSE AND THOSE OF THE GENERAL SYSTEM.

A. WORRALL PALMER, M. D.,
NEW YORK.

The longer and the more thoroughly I study the diseases to which the human system is a prey, the more I am impressed with the exceedingly intimate relation of one portion of the organism to another, or in other words, the dependence of one organ upon another. The healthy performance of the functions of one class of organs rests upon the normal condition or action of almost every other organ in the body. In this article I can present nothing original, but am satisfied to refresh your mind upon what you probably have already seen somewhere. The subject was suggested to my mind by three cases of nasal diseases occurring in my private practice last fall, one depending upon gout, another on masturbation, and the third on that many tendriled and poorly understood monster, uric acid diathesis. Since thinking it over in order to properly present it to you, I find it a very broad subject, therefore will scarcely more than mention the diseases so interdependent.

They may be considered under two heads: First, nasal and throat diseases dependent upon unhealthy conditions in other portions of the body. Second, diseases outside the dominion of the nose and throat dependent upon abnormal conditions of the upper respiratory track.

Probably the best understood is the influence of the zymotic diseases on the respiratory organs. In these we include scarlet fever, measles, roetheln, small pox and typhoid fever. In considering these we do not wish to think of the catarrhal conditions which form part and parcel of certain of these diseases, but of those that remain or come thereafter.

Most of these sequelæ are in form of a catarrhal inflammation or ulceration, and as such the point may be raised whether they are due to the ravages of the specific toxine of the disease or whether the disease has so lowered the normal resistance of the system, that other influences have better opportunity to cause unhealthy conditions in this region. The consideration of this is beyond the scope of this paper.

Suffice it to say here, that the general practitioner should keep a sharp lookout that after scarlet fever some severe or protracted case of catarrh of the nares, naso-pharynx or larynx does not supervene or that some inflammation of the nasal sinuses, an ulceration or necrosis of the cartilages or bones of the nose, does not follow. After these diseases ulceration of the larynx is rare, but diphtheria is common.

After measles we find sundry catarrhal conditions, especially of the larynx, diphtheria, œdema of the larynx, paralysis of the laryngeal muscles, inflammation of any or all of the tonsils, and epistaxis.

After roetheln, seldom do we have anything more than a prolonged simple catarrhal condition, anywhere from the nares to the trachea.

The sequelæ of small pox in this vicinity are usually ulcerations, or necroses of the cartilages, especially of the laryngeal or tracheal, which in turn occasionally cause cicatricial contraction of the air passages, or anchylosis of the crico-arytenoid joint, the two latter causing either interference in respiration or vocalization.

Following typhoid fever is found œdema or ulceration of the larvnx, which may proceed to necrosis of the cartilages, also paralysis of the vocal cords on account of a specific toxic neuritis of the recurrent laryngeal nerve.

Among the effects of disorders of the digestive tract we do not infrequently find catarrh of the mucous membrane of the nares and naso-pharynx. And if the specialist does not recognize this cause, and treat it or have it treated, all his endeavors to more than temporarily relieve the naso-pharyngeal trouble will be fruitless.

Diseases of the liver also annoy us in handling throat troubles. Either through the intimate relation between the liver and the adenoid tissue of the throat, causing inflammations of the sundry tonsils, or the obstruction to the portal circulation, causing congestion of the varicose or erectile tissue of the turbinates, which in turn produces a hyper-secretion and obstruction of the nares.

Furthermore, when we have an oft recurrent or obstinate case of epistaxis, we must not forget to ascertain if the patient may not have cirrhosis of the liver. If so, the greatest relief of the nasal hæmorrhages will be obtained by having the sufferer treated for his hepatic disease.

Next we notice that both the normal and abnormal conditions in the sexual sphere affect the nose, etc. Menstruation is frequently accompanied by a slight augmentation of nasal discharge and therefore a catarrh is almost always aggravated at this period. Cohabitation always causes a slight hyper-secretion or aggravates a catarrhal condition. What is commonly called the change of voice of a boy at puberty is principally due to a congestion of the blood vessels and

consequent thickening of the vocal cords in sympathy with the congestion and active changes going on in the testicles.

As these physiological conditions pertain in the economy it is not strange to find pathological ones, such as catarrh and inflammations with subsequent hypertrophies of the lymphoid tissue of the throat, consequent upon inflammations or chronic catarrhal diseases of the sexual apparatus.

This throat inflammation, I think, may be due to the manner which nature takes to throw off through the throat glands the poison, etc., absorbed through the glands of the sexual apparatus. This idea was suggested to me by a couple of peculiar gynæcological cases I had a few years ago, who could tell me by the taste when I had made an application of iodine or hydrastis to the osuteri.

Right here I desire to call attention to a cause of intractable hypertrophic naso-pharyngeal catarrh, accompanied with considerable secretion which we occasionally find in youths, which cause is, I think, too frequently overlooked, that is masturbation. A case that brought this forcibly to my mind was a boy seventeen years of age who had had a catarrh for two years, within the year previous to coming to me had been treated by two physicians with little or no benefit. It was such a severe case that at first I thought there must be some sinus implication, but upon thorough examination found not a single diagnostic symptom pointing thereto. Upon examination of the privates saw evidences of masturbation, to which practice the patient, after a little parleying, admitted he was addicted. To make a long story short, he was persuaded to give up the habit and with comparatively little treatment he made as much improvement in two months as a usual catarrh would have done in three times that period under the most assiduous care. The rapid improvement indicated to me the correctness of the opinion that the cause was a foreign one.

The last group of general diseases we will consider to-day, will be that elastic one, uric acid diathesis, rheumatism, gout and the diathesis as manifesting itself in the nose.

The most frequently observed sequel of rheumatism is a lacunal inflammation of the faucial, Luschka's or lingual tonsil; a chronic follicular pharyngitis may be found, seldom a benign ulceration of the pharynx, in the nose is a painful inflammation and swelling of the inferior and middle turbinated, which is non-reduceable with cocaine, and only relieved by remedies indicated for rheumatism; and in the larynx is a fixation of the vocal cords which is occasionally but erroneously diagnosed, paralysis; it is really due to ankylosis of the crico-arytenoid articulation.

The common manifestations of gout, any of which are rare at best, are recurrent quinsy and chronic pharyngitis. A gouty deposit may locate itself in the crico-arytenoid joint and a tophulus has been observed in a vocal cord.

Some authority, I forget whom, considers hay fever a form of gout. Be that as it may, I do not feel able to pass an opinion. I have had two interesting cases of pseudo-hay fever, which were but little benefited by the usual treatment therefor, but which were relieved by

medicine and means which are believed to reduce the uric acid circulating in the blood.

Another peculiar case now under treatment is that of maxillary sinusitis, which has been more relieved by auti-uratic treatment than others. In regard to this maxillary case, I may mention that this is the last of a series of dispositions of pus in different parts of the patient's body, which sundry conditions have been attended by different specialists within whose domain they occurred.

Again, frequent epistaxis may be an early symptom of Bright's disease; it is occasionally the first to draw our attention to this deep lying disease, while in the later stages it is sometimes a precursor of a uræmic attack, or of a hæmorrhage in some more important organ, such as the brain.

There are a few other exceedingly rare occurrences with which I will not take your time now, but will proceed with the second division. The nasal and throat diseases causing pathological conditions elsewhere. These may be generalized under three headings: First, those caused by reflexes; second, by auto-intoxication, and third, by interference with normal functions of the parts.

Of the first heading, the best known are the asthma and the dry cough consequent upon irritation of the turbinated mucosa by a spur, deflection, synechia, etc. These same conditions either from causing a continuous cough or from the direct irritation to the nervous system can after a time bring about an emphysema. In like manner, the intervention of protracted coughing, emphysema may be caused by elongated uvula, lingual tonsillar hypertrophy or follicular pharyngitis.

The next best recognized are the group of eye reflexes. This is composed of phlyctenular conjunctivitis, blepharitis, asthenopia and myopia, any of which may be caused by pressure upon the turbinated of a spur, ridge, polypus or deflection. There is a record of a case of exophthalmic goitre disappearing after removal of polypi.

Among the neurotic conditions of the heart we find cases of palpitation and tachycardia, or rapid pulse, being relieved by excision of spurs, etc.

Under auto-intoxication, the most frequent is a chronic dyspepsia consequent upon the constant swallowing of the discharge from a chronic naso-pharyngeal catarrh or sinusitis. In like manner the irritating or poisonous pus from a nasal sinus empyema may produce recurrent tonsillitis, acute suppuration of the middle ear, meningitis, phlyctenula conjunctivitis, or chronic bronchitis. This latter appears like consumption, and I know of two cases mistaken for and treated as such. These were relieved by operative measures on the sinuses.

The obstruction of the nares, such as turbinated hypertrophies, deflections, ridges, and polypi, may result in deafness from not allowing proper æration or atmospheric pressure in the naso-pharynx. While hypertrophy or depressed position of the anterior end of the inferior turbinated may be occluding the nasal outlet of the nasal duct, induce a phlyctenular conjunctivitis and I should think might produce a dacryocystitis, although I have not seen such a case.

One of the most frequent ill results of hypertrophy of either or both

the faucial and Luschka's tonsils is suppuration and chronic catarrh of the middle ear. Another bad effect of these last hypertrophies is a depressed condition of the anterior walls of the chest, diminishing the proper capacity of the lungs and therefore the normal oxydation of the blood.

Finally the spread of disease or inflammation by contiguity of tissue may explain the reason why sometimes a dermatitis, or even erysipelas may follow intra-nasal inflammation, as also why melancholia or delirium accompany inflammation in the frontal, ethmoidal or sphenoidal sinuses.

In conclusion may I mention the object of this cursory résumé of this subject, if I have not already sufficiently inferred it. First, we as specialists must not confine ourselves while searching for the cause of a disease too closely to just the tissues or functions exactly within our own domain, but should examine the patient and not his respiratory tract.

And second, I think it behooves the progressive general practitioner to sufficiently accustom himself to the use of the usual examining instruments for the nares, etc., as also the normal appearance of such organs, to recognize the possible causes therein for some more troublesome condition elsewhere for which later the patient may consult him.

DISCUSSION.

IRVING TOWNSEND: As Dr. Palmer correctly stated, this subject is too broad to discuss in detail within the limits of a short paper and it can hardly be outlined fully in such a brief article as he has written. He has succeeded in comprehending as many suggestive points on the relation of local to exanthematous and diathetic diseases as could be expected in the limited space allotted to one paper. There is much to be said on every subdivision of the subject, but most of it is familiar to you and therefore I will confine my remarks to two or three points not fully elucidated by the writer and which are of considerable practical importance.

The most serious and frequent sequel of the exanthematous and infectious diseases is catarrhal or suppurative disease of the middle ear, which I think was barely alluded to in the paper. The best proof of this is the fact that a large proportion of ear patients date the beginning of their aural trouble to an attack of one or another of these diseases. It is difficult to decide whether there is greater danger from the extension of the acute inflammation of the mucous membrane (so prominent a symptom in such cases), to the middle ear, or from the mechanical effects of the lymphoid hypertrophy in the naso-pharynx, which so often follows scarlet fever and diphtheria. In either case the relation is apparent between the local and the general disease, and it is reasonable to believe that often the specific toxic principles (characteristic of the disease) are responsible for local complications.

Impaired digestion and torpid liver are so often associated with the uric acid diathesis that they might be considered together in relation

to the local trouble, and should be given more attention than they usually receive. The connection between sexual derangements and diseases of the nose and throat is often observed, as the writer states, but I think it should be considered as a reflex neurosis, rather than attributed to any direct relation between these organs. I would also consider a co-existing catarrhal inflammation of the throat and sexual organs due to a constitutional predisposition (a tendency of all mucous membranes to inflammation) rather than assume that the disturbance of function in the membrane of one organ resulted directly from that existing in the other. The variety and number of the troubles (classed as reflex neuroses) caused by irritation in the nose and throat are almost unlimited, so that a full discussion of them is impossible at this time. The writer mentions many symptoms arising from reflex irritation, and includes a few that could be better accounted for as the direct result of an extension of the original disease. Dry cough is so often due to dryness of the pharynx from nasal obstruction and mouth breathing, and conjunctivitis, and from direct extension of the inflammation from the nose to the eyes, that I should hesitate to class either as reflex neuroses. The term neuroses, as here used, should be limited to those phenomena only that are not the result of extension of the inflammation to adjacent tissues, nor that are mechanically induced from nasal obstruction or other direct causes.

The throat lesions of tuberculosis, syphilis, scrofula, etc., are not mentioned, but perhaps are not within the scope of this paper. The throat shows a variety of conditions recognized as indications of the lithæmic state, such as tonsillitis, and pharyngitis follicularis and perichondritis laryngeas, etc. The characteristic symptom of rheumatic throat affections is that the pain is much greater than the local inflammation of the throat accounts for. I have never seen a case of ulceration or fixation of vocal cords which I considered due to lithæmia, and I should hesitate to attribute such lesions to that origin. The uncertainty regarding the pathology of rheumatism and gout leaves the individual physician free to exercise his judgment in making a diagnosis; his chief means of verifying his conclusion is by a study of the urine, and the amount of relief obtained from rheumatic treatment.

The writer has done admirably in his endeavor to outline the question, and doubtless would hesitate to attempt the task again under the same conditions. The practical nature of the subject is very apparent, and I should like to hear it discussed from the various standpoints suggested by the writer. While I agree with the conclusion that it would be a good thing if every physician could examine and make a diagnosis of the condition existing in the nose and throat of each patient, it is practically impossible for the majority of practitioners to find time to acquire the necessary training and technical skill to do so satisfactorily. We should always remember that nasal obstruction and mouth breathing are abnormal, and may cause a variety of symptoms, either in adjacent or distant parts of the body. To my mind, this fact is paramount in importance to all others, and being so readily recognized, is not likely to be overlooked if due attention is given to the subject.

It is not my intention to minimize the importance of the many other local indications of systemic disease, which appear in the nose and throat, but to emphasize the need of a careful scrutiny of all cases with obstructed noses, or who are compelled to breathe through the mouth.

DISEASED TONSIL AND ITS TREATMENT.

CHAS. E. TEETS, M. D.
NEW YORK.

The most common form of diseased tonsil is hypertrophy but the object of this paper is not to call attention to that form of hypertrophy so frequently seen, particularly in children, when the tonsils are of the hyperplastic variety and so enlarged as to occlude the faucial passage and interfere with both respiration and drainage. Such enlarged tonsils are usually removed by the educated physician providing the consent of the patient or of those closely related can be obtained. I allude, however, to a condition where the enlargement may be but slight, yet transgressing the normal limits of the healthy tonsils, the pillars of the fauces, and therefore diseased. The ordinary examination with the tongue depressor does not always reveal the increased volume of the hypertrophied tonsil and it is only when the tongue depressor is forced back far enough to make the patient gag, when, by the contraction of the constrictor pharyngeus the tonsil will be thrown out from between the pillars, that the abnormal condition is recognized. Sometimes these glands are flat and chiefly enlarged in the vertical direction, being elongated in some cases to such an extent as to press upon the tongue or epiglottis producing an irritating cough and a frequent desire to clear the throat. There is often various reflex symptoms such as nausea, vomiting and a tickling sensation in the pharynx or larynx. The tonsils may also be enlarged in the antero-posterior direction so that but little protrusion of the glands inwards is noticeable. Enlargement in this direction prevents free action of the palate and interferes with the action of the muscles which open the Eustachian tube, and may be the cause of deafness, pain in the ear and various other reflex symptoms.

The lacunæ of the tonsils are larger than normal, the diseased condition acting in such a way as to draw outward upon the walls of the crypts, creating abnormally open-mouth lacunæ. In addition to the particles of food which are often crowded into these enlarged pockets there also accumulates the débris from broken-down follicular glands, epithelium, pus corpuscles and other waste matter. When profuse and remaining long there is always a tendency to decomposition. If this cheesy matter is not visible it may often be expressed from the lacunæ by making pressure in their vicinity. These masses are usually extruded in the form of small pellets, and owing to pro-

longed detention are very offensive. Sometimes there appears near the surface of the tonsil a distended yellow mass covered with mucous membrane; this condition is due to a retention of the secretion within the crypts, and on incising there is exuded a creamy liquid.

Such tonsils are usually adherent to the anterior or posterior pillars, sometimes to both, and in some cases we find the anterior pillar not only adherent to the tonsil but intimately grown into it at the upper portion of the gland. Dr. Clarence Rice says: "When I examine a tonsil for the first time during an attack of acute inflammation, and find it quite free from adhesions, I feel confident that suppuration will not ensue." It is a fact which I have demonstrated many times that after separating the adhesions between tonsil and pharyngeal pillars and properly treating the tonsil with the galvano-cautery, the patient rarely has another attack of suppurative tonsillitis.

When there occurs such changes in the tonsils as I have described, there will be found associated therewith other conditions which will not disappear until the diseased tonsil has received the proper treatment. Among the conditions that can be traced to a diseased tonsil are, first, chronic gastric catarrh which results from the swallowing of diseased tonsillar secretions. Those who have noticed the odor of these putrescent masses, will have no doubt whatever as to their infecting nature and power to interfere with the general health of the patient. The tongue is often coated, the breath tainted and associated with these are other symptoms of indigestion. The saliva in the oro-pharynx is more profuse and frothy than in a normal throat, due to the stimulating action of the diseased gland upon the neighboring mucous membrane. In singers and those who are accustomed to prolonged use of the voice, after vocal exertion there comes a condition of huskiness and sometimes even pronounced hoarseness. There is required also a greater muscular exertion and strain to execute the notes of high register and sometimes the singer gives up in despair. A condition of chronic pharyngitis is frequently present and the patient usually gives a history of previous attacks of lacunar, parenchymatous or peri-tonsillitis.

Why are these diseased glands allowed to remain to infect and interfere with the normal action of neighboring parts? It is because the physician fails to recognize this change in the tonsil and does not attribute the symptoms which I have enumerated to its abnormal condition, or recognizing the conditions described, and realizing the obstacles to be met with in the removal of a gland so well imbedded, prefers to prescribe internal remedies, astringent applications and gargles which however can never produce a radical cure.

The process of igni-puncture is practiced by many. The operation consists of entering the lacunæ one after the other with a cold platinum cautery point and after heating the same cause it to burn its way out. I made use of this method of cauterization twelve years ago and while some cases seemed to be benefited by such treatment, in the majority of cases the results were not satisfactory. There was not much absorption of the gland and generally a very ragged tonsil was left to entangle

food particles and keep up the irritation and reflex symptoms previously mentioned.

Several years ago I practiced a method which has been frequently reported in the journals. It consists of inserting the point of some instrument, such as a small bistury into one of the cryptic orifices and bringing it out at a neighboring orifice, or forcing it outward through the tissue. Several crypts may be opened up at one sitting and if there are any loose tags of tissue remaining, which is often the case, they may be trimmed off with a pair of curved scissors. To diminish the tendency of the cut surfaces to unite, I applied a solution of trichloracetic acid. While this at the time seemed to be a most satisfactory way of treating the tonsils, later on I was convinced it was open to some objections. First, it left a somewhat irregular or ragged surface arresting particles of food, and secondly, owing to its roughness, was not only a source of irritation but also of interference with the best production of vocalized sounds.

I believe in removing as much of the diseased gland as possible, leaving a smooth surface. Owing to the small size it is very difficult and often impossible to grasp them with the tonsillotome. Ingals' method of eradicating small diseased tonsils is to grasp them with a Vulsella forceps, encircle them with a cold wire or galvano-cautery snare and thus attempt their removal. I have removed tonsils in this way several times, but it is not always satisfactory as there is frequently left a portion of the abnormal tissue. There has also been devised a punch forceps for the removal of diseased tonsils which could not be grasped with the tonsillotome. Those who have made use of these forceps claim to have had satisfactory results.

I have for the past nine years employed a method for the removal of diseased tonsils which is more satisfactory than those heretofore described. It is to dissect out the diseased gland with the electrocautery. Three or four sittings are required to completely and thoroughly remove the diseased tissue. Pynchon advocates the dissection of the whole gland at one sitting. This would be the treatment par excellence if it was not for the marked inflammatory reaction which I have found difficult to control. Furthermore the operation is somewhat tedious, requiring from a half to one hour's time. The duty of the physician is not only to thoroughly remove the diseased tissue, but to do it in such a way as will cause the least pain and inconvenience to the patient.

The technique of this operation is as follows: first, a solution of cocaine ten per cent. is applied to the tonsil to be operated upon which will produce some anæsthetic effect. The operation, however, is not painful. During the operation the tongue depressor must be employed and this must be held by the patient or a self-retaining depressor may be used. All adhesions between the tonsils and faucial pillars are first divided. The tonsil having been released, the next step is to grasp the gland with a suitable forcep and lift it out towards the median line, and then with properly bent electrodes dissect a portion from its attachment to the pharyngeal aponeurosis.

The point of the electrode should be at a white heat as this will give

the least pain, best results and lessen the hæmorrhage; the dissection should be done slowly doing but little cutting at each stroke. The anterior and upper portion should be removed at the first sitting, ten days should intervene before the second operation. Sometimes a small tonsil can be removed in two sittings but usually three is required. If the operator is careful not to burn the pharyngeal pillars there will be very little inflammatory reaction. It must be remembered that the pillars resent any traumatism.

Immediately after the operation, I make an application of camphophenique. This is followed by an insufflation of orthoform powder. This not only prevents the inflammatory reaction sometimes following the operation but also produces anæsthesia lasting from twelve to eighteen hours, allowing the patient to eat and drink without pain. These applications are repeated every day for one week.

The advantages of this operation are, complete removal of the diseased tissue, an even surface, little or no hæmorrhage and a wound protected by a seared surface. In every case where I have employed this method of removal the cure has been perfect, with entire relief from the attendant symptoms, and in nearly all cases there is immunity from further attacks of suppurative tonsillitis.

REPORT

OF THE

BUREAU OF PÆDIATRICS.

"Cases Illustrating the Importance of the Early Recognition of Pulmonary Invasion," - - - WILLIAM W. VAN BAUN.
"The Indicated Remedy," - - - - GEO. E. GORHAM.

CASES ILLUSTRATING THE IMPORTANCE OF THE EARLY RECOGNITION OF PULMONARY INVASION.

WILLIAM W. VAN BAUN, M. D.
PHILADELPHIA.

The tendency to neglect the so-called trivial complaints seems irresistible, the responsibility resting equally upon the patient or guardian and the physician. In no disease is close, experienced observation so necessary as in incipient consumption, and yet how frequently a cold with a cough, especially if it be associated with a catarrhal throat, is

permitted to run on with faint-hearted attention only. A majority of such cases fortunately, or unfortunately, get well without active, skilled assistance, and it is this fact that gives rise to fancied security and lulls the patient and physician to sleep to the necessity for help until the physical signs demonstrate that an alarming invasion has taken place unrecognized. It is well for the profession and humanity that no register has been kept of the lives sacrificed by such neglect, arising from the condition being unsuspected, or from an unwillingness or carelessness in making frequent, careful chest examinations.

The chance of error in these primary conditions is great and the physician is in danger of being termed an "alarmist," but this does not excuse the making of frequent examinations in all catarrhal cases with cough or even in those without cough, if there is a history of shortness of breath, with sternal weariness or oppression, and partial giving out of the voice on talking, in otherwise healthy individuals. Such a condition is always suspicious and calls for careful physical exploration of the chest and throat. These cases unfortunately consume a great deal of time and require a greater experience than those with a pronounced lesion. In the latter, with the well-known signs of consolidation, dullness, increased fremitus, feeble or suppressed vesicular murmur and extended bronchial breathing, the case is established; but in the absence of these signs, easily detectable, it often tries the best ability of the expert to say positively such is merely bronchitis, or the insidious onset of phthisis. Of all the diseases to which man is liable there is none in point of destructiveness to be compared with tuberculosis; no one is necessarily exempt, and the claim for unceasing watchfulness is imperative. The time to cure phthisis is in its incipiency and not when the patient is losing flesh, and has a cough, expectoration, diarrhœa, night sweats, and marked pulmonary changes. The diagnosis can be made as a rule long in advance of such changes in run-down catarrhal conditions, if there be sputa, by means of the microscope, and if tubercle bacilli are present in either large or small quantities the case is one of tuberculosis. Their absence even after three or four carefully made examinations does not necessarily mean immunity, and in these cases if health is not quickly restored tubercular trouble is to be anticipated.

The use of the reaction from tuberculin as a means for early diagnosis has many ardent supporters, and numbers of adversaries. Its adherents claim that it enables a diagnosis of the disease at the very start as tuberculosis, even before sepsis or pulmonary indications are present. The tuberculin is injected hypodermatically into the "suspect" and if tuberculosis is present, in any part of the body, a febrile reaction takes place in from six to twelve hours, beginning with chills, pains in the back, headache, rise of temperature, etc. If no tuberculosis is present it has no effect. The tuberculin does not aggravate the tuberculosis if present, and it does not start a tuberculosis if it is not present. The weak point is that some patients known to have tuberculosis fail to react to the tuberculin.

The following illustrates some of the difficulties met with in practice in handling this class of cases:

CASE 9-387.—Acute Pneumonic Phthisis.—On November 29th, 1894, I saw at her home a plump, well-built girl of fifteen years; her father and mother were living and in good health and there was no family history of phthisis. A month before this date, after exposure to cold and wet, she was taken with a chill, rapid rise of temperature, pain in the right side, cough, mucoid expectoration (which never presented rusty characteristics), rapidly increasing respiration. At the end of three weeks no improvement was manifest, in fact the general symptoms were worse, the pulse being rapid, the temperature erratic, reaching 103.6 F., with frequent sweatings and a constantly increasing muco-purulent expectoration. At the end of another week, her condition being worse, she came under my care. She was five feet in height and weighed about one hundred and five pounds, having lost ten or more pounds during her illness of the month previous. She was feverish, short of breath, with bluish lips, and rapid, irregular pulse, temperature 103°, with profuse night sweats, was weak and languid in morning, regaining her strength in the afternoon, with the oncome of hectic. The whole right lung was affected, with signs of consolidation, dullness, increased fremitus, with feeble vesicular murmur, and characteristic bronchial breathing. Her expectoration by measurement was a full quart in twenty-four hours. There were indications of softening, but no signs of cavernous formation. The microscope showed presence of elastic tissue and myriads of tubercle bacilli. The diagnosis was acute pneumonic phthisis with a guarded prognosis, far more hopeful than the condition warranted, suggested by the distress of the mother. She was immediately put to bed, with directions for night and morning sponging with alcohol and water, to be used also every three hours when the temperature rose above 103°, the temperature of the water being gradually lowered until that of 50° could be used without complaint, and with good reaction. A general skilled massage with enemata, if necessary; hyper-alimentation, with an easily digested, highly nutritious diet; a well-ventilated room kept at a uniform temperature of 72° during the entire twenty-four hours of the day. She was ordered to use an inhalation mask, the medicament being creosote, terebene, alcohol and chloroform in equal parts, commencing with ten minutes' inhalations three times daily, which were rapidly extended to one hour, morning, noon and night. She was carefully taught proper thoracic and diaphragmatic breathing which was insistently persisted in, and she was given internally chininum arsenicosum 2x, trituration, two grains every three hours. This treatment in all its details was carried out by skilled assistants without the slightest omission for two months; at the end of ten days her expectoration was increasing slightly, which was discouraging; then it began to rapidly decrease, and, at the end of the fourth week, it was less than an ounce, containing no elastic tissue, but still showing an occasional bacillus. At the end of the sixth week there was not enough to make a slide and there has been none since. Her temperature was taken every four hours—it reached and remained normal all day and night during the middle of the fourth week—and she was permitted

to get up. Her appetite was good and she rapidly regained her lost flesh. From this time on her recovery was uneventful, the lung rapidly clearing up, except a small area of consolidation in the third interspace. This was carefully watched for two years, frequent examinations being made, at the end of this period it had not entirely cleared. She was encouraged in all outdoor sports and constantly gained in muscular strength, becoming robust.

NOTE.—On February 5th, 1899, she was a well-developed girl, weighing 125 pounds, with a muscular system in prime condition, she having developed decided athletic tendencies. There is still slight evidence of consolidation, probably due to cicatricial formation and pleural thickening, and while appearing to be perfectly well, any return of catarrhal symptoms or cough will demand careful attention.

CASE 10-123.—Incipient Phthisis.—Came under treatment June 8th, 1896; she was a well-developed, well-nourished girl of twelve years, with cough and frequent hawking to clear throat of mucus expectoration, husky voice with hoarseness worse at night. She received treatment and returned once or twice, reporting improvement. Her menstrual function was established in December, 1896. In March of the next year she caught cold, of a severe catarrhal type, with earache, the menstrual period being delayed. The earache was due to an acute suppurative otitis media of the left ear with impaired hearing, she being able to hear a watch tick at eight inches only, which the right ear heard at twelve feet. The cold clearing up, special attention was given to restoring the hearing; she was under treatment occasionally until June, 1897, when she could hear the watch distinctly with both ears at eighteen feet. While the catarrhal condition of the naso-pharyngeal mucous membrane was greatly improved, the voice remained husky. The improvement continued during her summer outing. In the fall she returned for a menstrual irregularity, the flow being profuse, dark, offensive, lasting six or seven days, weakening in its effect, her mother reporting that her cough and catarrhal condition was invariably worse at these times. In December, 1897, the cough increasing with wheezing and some dyspnœa, her chest was thoroughly explored. I had considered the cough to be merely an ordinary bronchitis. Her parents were both living, her father being in perfect health; her mother, however, was a neurasthenic, entering upon the climacteric, suffering greatly, and with a history of phthisis on her maternal side. The girl had a good chest formation, was fourteen years old, five feet one inch in height, and weighed 105 pounds. Inspection showed an impairment of the respiratory movement, especially of the right side; but it was not marked. Expecting a sub-acute bronchitis, I was not surprised by finding fine mucous rales, but I was alarmed by discovering a weakned broncho-vesicular jerking respiration in the upper third of both lungs. It is not usual to find a beginning primary lesion in the extreme apex of a lung; experience teaches that it commences about an inch to an inch and a quarter below the summit of the lung near the posterior border and can be earliest ascertained by examining behind in the supra-spinous fossa; percussion in this region on the right side gave evidence of dullness, while

the left was sympathetic, although harder to detect. Any dullness, however slight, in this locality, is always abnormal and the presence of a jerking respiration and rales did not tend to relieve my anxiety for my patient. The girl was in good condition for recovery, and active, persistent medication was commenced and continued in, reliance being placed on the iodides, especially of arsenic, antimony and calcarea, with intercurrents as needed. At the end of three months nothing seemed to have been gained; she was no worse, however, excepting monthly aggravation before and during the menstrual period. March, 1898, found the physical signs the same; her catarrhal symptoms were annoying, but her general health remaining good was encouraging to continue medication. Towards the end of April her condition began to yield and by the end of May no rales could be heard and at this monthly period there was no aggravation of the catarrhal symptoms, careful chest explorations being made before, during and after the period. As a complication an annoying leucorrhœa appeared. The patient had increased in weight and her general health was excellent. June 9th, 1898, was the last opportunity I had of examining her lungs; the suspicious spot in the right apex had disappeared, the left being normal and there were no rales. The jerking respiratory murmur remaining.

Here was a case overlooked, on the verge of an invading phthisis, which would probably have gone on to a chronic ulcerative consumption. It was a narrow escape and it demands that catarrhal symptoms shall not be neglected, especially during the period of adolescence. The practical lesson is the necessity for accurate surveillance of the throat and chest in coughs and colds. If they are permitted to go on unobserved and neglected, they may become the prelude of a definite increasing lesion, whereas discovered in time the greater will be the probability of a cure, especially in this period of great vital force and recuperative energy.

CASE 9-292.—Acute Caseous Broncho-Pneumonia.—A girl, aged fifteen years, height five feet, weight 110 pounds. Her early history was like the preceding case, excepting that there was no hereditary taint of consumption, this being in her favor. Her father and mother enjoyed excellent health, as also their only other child, a boy of fourteen years. She was well-nourished and had previously enjoyed good health, excepting an attack of measles when 8 years old. The last two years she had had a catarrhal throat with hawking of phlegm accompanied by infrequent coughing. I saw her at my office on June 30, 1897; six weeks previously she had caught cold, with frequently repeated chills, which were not severe. Three weeks later she had a pulmonary hæmorrhage, which was followed by high fever, chilliness, increase in pulse rate and rapid respirations, accompanied by gradual loss of flesh and general weakness. On examination the physical signs were definite and clear cut, resonance was impaired to a marked degree of dullness, the pitch was heightened and the sense of resistance greatly increased, the respiratory sounds being harsh and tubular. In spite of her hectic flush, which was misleading her parents, her drawn blue

lips, with her apparent shortness of breath, and chest weariness which was complained of, were disquieting for her future. In response to an unfavorable prognosis, her father, who accompanied her, replied that he considered that I had overestimated the seriousness of her case. This was a poor start. I requested to see her frequently during the next four weeks and that an arrangement be made to take her to the mountains. I saw her four times in as many weeks and failed to impress them with the necessity of doing anything for the girl which she did not care to do. By this time softening had set in, with sweats, chills and increasing emaciation, the sputa showing elastic tissue and bacilli. The family getting alarmed took her to Atlantic City with a party of young people for diversion; growing rapidly worse she returned to the city and died three weeks later of phthisis florida. The case was one of broncho-pneumonia, with caseous deposit in the smaller bronchial tubes and the products of catarrhal pneumonia in the air-cells.

CASE 10-161.—Incipient Phthisis.—Aet. 21 years. Was seen on May 24th, 1898, presenting the by no means unusual history of a catarrhal throat, with frequent colds and cough, which had been hanging on all winter, it having commenced in October, 1897. His general condition was good, his explanation being, "if it were not for my cough and expectoration and a sense of weakness with short-windedness, I would have no need of a doctor." His few short words summed up his case characteristically to one capable of interpreting the meaning of his symptoms. Physical examination showed an invasion of both apices. He was treated at home for one month with ferrum phos. and chininum arsenicosum, with improvement. He was then sent to the mountains of Eastern Pennsylvania in search of the healing value of fresh, pure air and in order not to get away from a good source of supplies for a suitable diet, for the success of systematic conservative drugging largely depends upon a combination with proper climate, hygiene and diet. He returned home, reporting a gain in weight of ten pounds, and well marked muscular improvement. His sputum, while lessened, still shows a few bacilli. The evidence of consolidation in his apices remains. The signs in the other lobes of the lungs are negative and yet experience teaches us that, as a rule, when the physical signs of the disease in the apex are such as can be easily demonstrated, the lower lobe is already affected and this is the probable condition in this case. If the real significance of his cough had been appreciated in November, 1897, he could probably have been saved from the chronic ulcerative phthisis that is now threatening him.

CASE 10-244.—Incipient Phthisis.—An overgrown boy of eighteen years, of healthy parents and with a negative tubercular heredity; weight 115 pounds, height six feet, three inches. Throat troubling him, coughing, and is sure he has consumption. Impaired resonance at left apex with crackling rales, indicating a circumscribed pneumonia, sputa negative. He was seen in early May, 1898, and was sent immediately to the mountains with instructions to lead a careful outdoor life; and was kept on iodide of arsenic for four months with

marked improvement. He is under observation this winter, with anticipation of a complete cure. The cough in this case his parent attributed to nervousness arising from his extraordinary rapid growth. I insisted on a three-hour temperature chart being kept for ten days. It revealed an irregular temperature with excursions of two to three degrees; its significance was at once realized by all and his chances for recovery were improved thereby.

By way of generalization, there is evidently much we do not yet understand in regards to the development, course and ending of phthisis. Why some get well and many do not is still unsolved. Climate, hygiene, diet and therapeutical measures, frequently bring about cures or periods of rest lasting for months or years, which are yet not permanent, for after a shorter or longer time the disease reasserts itself and pursues its course to a destructive end. Still there are enough instances in which the phthisis has been controlled and a lasting stop been put to its progress to encourage us to use every means at hand to prolong the life and cure each individual case.

The presence of bacilli I look upon simply as confirmatory evidence for we seem to know but little as to how they get into the body, or as to the period during which they are able to exist.

The search for a sovereign remedy as a specific against consumption has been fruitless and the outlook for such in the future is not encouraging.

The feature of greatest importance in these cases is to recognize as early as possible the incipient lesion and to act vigorously accordingly.

THE INDICATED REMEDY.

GEO. E. GORHAM, M. D.,
ALBANY.

In December, 1897, Arthur S., aged 3½ years, was brought to my office with the following history: Until six months ago a strong, healthy, well-nourished boy. It was then noticed that he tired easily and was losing flesh. There was soon added to these symptoms diarrhœa, elevation of temperature and sweating at night, and for the last three months the most severe abdominal pain. Night after night the child would writhe and scream in the most agonizing pain until exhausted if not quieted with opium. For the last month the child too weak to walk. On examination I found heart and lungs normal, abdomen distended and temperature 101°. The character of the stools, the irritability, wanting now this, now that and satisfied with nothing, would seem to indicate chamomilla. Silicea and calc. carb. were also suggested by the symptoms; but ignoring all symptoms I sought for the cause.

I suspected commencing Pott's disease from the abdominal pain, the loss of flesh and rise of temperature. There was no curvature and no lateral deviation of the spine though two of the lower dorsal seemed a little prominent. There was some rigidity of the back not noticeable when stooping, but to be detected by lifting the hips. The child was placed upon a wooden frame covered with canvas and a piece of canvas placed over the body and nailed to the sides. In this position he was kept constantly for three and a half months, going out daily for a few hours.

A generous diet of milk, fruit, eggs, graham bread and a little beef was ordered. Iodoform 1x was given three times a day. The pains were relieved in a few days. The temperature gradually became normal, diarrhœa ceased and rapid gain in flesh and strength followed; so that in four months the boy was discharged well and has remained in perfect health to the present time. Prescribing an indicated remedy for six months had done the child no good. The true remedy being indicated here was rest, complete and prolonged, and the most satisfactory results followed its application notwithstanding the claim of some that prolonged, fixed recumbency is injurious.

In July, 1898, Ethel L., aged 4 years, was brought to me by her mother for an irritation of the vulva. For a year the child had had some leucorrhœal discharge with redness and itching externally. She was often seen pushing the vulva against a chair leg and digging with the hand. She was very irritable and started and jumped and often cried out in her sleep. Many remedies are indicated here, but on close examination I found the clitoris tightly embedded beneath a closed hood. Under chloroform I released the hood, removed some smegma and all the troublesome symptoms which had been persistent for over a year, notwithstanding the indicated homœopathic remedy, local washes, etc., were entirely relieved within a week and have not returned.

In January, 1898, I undertook the treatment of Lydia N., an overworked school-girl. She was anæmic and weak, with cold perspiring hands, no appetite, obstinate constipation. She complained of distress after eating. It was only by much tact and urging by a sympathetic mother that she would eat any kind of food. For two months she was given the best indicated remedies I could select with malt redbone marrow and other food tonics with no improvement. She then was put under the care of an eminent specialist who placed her in bed and ordered forced feeding of hot milk, eggs, etc., and was given iron and strych. comp., valerian alts., etc. She improved slightly and was sent to the mountains. Not improving she returned to the city and to my care again. She then had hysterical ptosis. She was still very weak and anæmic. A walk of one block completely exhausted her. Food would be vomited as soon as eaten. Having failed in my attempts to isolate the child from the family I tried to explain to the mother that her sympathy and anxiety was keeping the girl ill. The mother was offended and in explanation I said: "You do not understand me. Your daughter has a dual life; an unconscious and a con-

scious life. The unconscious life presided over by the great sympathetic nervous system and the conscious by the cerebro-spinal system. Now when I find fault with the girl's stomach and say she can eat, I am not thinking of her conscious life—of the child as you see her and love her—but of that unconscious life. And that unconscious life is taking its cue from the thoughts in her mind. Do you not know that when you see another vomit often your own stomach will take the hint and eject its contents. Do you not know that when you think of eating an apple or an orange your mouth will fill with water? And what is that but the process of digestion, stirred up by a thought in your mind? Can you not see that what you think and what this girl thinks has much to do with the functional activities of her unconscious life? You expect her to be ill, to vomit when she takes food. She expects to and her sympathetic nerve takes the hint, gives the order and up comes the food. Now what I want you to do is to think as I do. That there is no sense or use in that unconscious life acting in this way. It can and it will take care of her food." The mother and child both caught the idea and their sympathy and fear were quickly changed to a firm determination to make that stomach do its work.

In less than a week the child was eating heartily all kinds of food and walking out daily. In four weeks she was well and strong and has remained so. Here the indicated remedy was a proper thought.

Perhaps the report of isolated cases is of no value, but these were all cases of months' standing and steadily getting worse, and they were all promptly and permanently cured. Hahnemann, Herring, Dunham, Lippe, Farrington, Allen and others have taught us to study the totality of symptoms and then to administer the drug whose pathogenesis most closely corresponds. Brilliant and satisfactory as are the results in many cases, the most efficient prescriber is frequently doomed to failure and disappointment. And why? Not necessarily because he is unable to select the indicated drug, but because so important is the selection of the indicated remedy considered and taught that the mind of the prescriber is fixed on this one thought, narrowing his vision and causing him to overlook more important and vital questions of etiology and pathology. The physician who studies his cases carefully for pathological points, he who searches carefully for transgressions of hygienic law may often find more important and more effectual work to do than to study his materia medica and administer a drug in high or low potency.

REPORT

OF THE

BUREAU OF PUBLIC HEALTH.

"A Peculiar Type of Small Pox," (Illustrated,) - - F. W. ADRIANCE.
"The Pollution of Public Water Supplies," - - - W. H. HODGE.
"Hygiene of Consumption," - - - - BURT J. MAYCOCK.

A PECULIAR TYPE OF SMALL POX.

F. W. ADRIANCE, M. D.,
ELMIRA.

A disease whose history and characteristics are so well known as is variola and whose symptomatology and diagnosis is so complete, it would seem should be readily recognized, even by those who have had no previous experience with it.

During the summer and fall of 1898, and at some points even up to the present time, small pox has been very prevalent in many different localities in Southwestern New York and Northwestern Pennsylvania. The type of the malady has been remarkable in that it departed so materially from the usual expression of the disease, making its recognition difficult in nearly every locality where it manifested itself. Many physicians who had had experience in the treatment of small pox failed to recognize it in its present type and it was diagnosed as chicken pox, herpes, ecthyma, impetigo contagiosa and varioloid.

In the majority of localities where it appeared I am informed that not until it was vigorously insisted upon by officials of the State Boards of Health of New York and Pennsylvania were the proper measures of quarantine and sanitary precaution put into operation, usual in the care of patients suffering from this disease. This arose from the general doubt on the part of the profession and laity as to the true nature of the condition with which they were contending.

For the purpose of comparison a brief consideration of the symptomatology and diagnosis of small pox collated from various sources shows the following:

It is described as being a disease highly contagious, extremely dangerous, literally to be dreaded, with violent onset, severe chill and excruciating pain in head and back. The period of incubation from ten to fourteen days. A violent chill ushers in the condition, followed

by high fever, the temperature in the first day ranging from 103° to 104°, great prostration, severe headache, vomiting, great pain in the loins. The initial stage usually lasts about three days, at the expiration of which the eruption manifests itself. The temperature generally increases up to the time of the appearance of the eruption, when it falls nearly or quite to the normal. The pulse during this stage runs from 100 to 120.

The eruption, either macular or papular, appears first on the forehead and face, gradually extending to the entire body; it also may appear in the mucous membrane of the mouth, pharynx and at times the deeper structures. The macule or papule presents a shotty feel under the skin to the touch. On the sixth day the papules contain a milky serum, protrude like half peas and present a slight umbilication which soon disappears. On the ninth day a full round pustule is present. At this stage the fever returns or increases, rising to 102° or 103°, constituting the fever of suppuration. The pustules become confluent and again present an umbilicated appearance, the contents escape and become dry, forming crusts. (It is at this point in the course of the disease that the characteristic odor of small pox should present itself; an odor so peculiar in its offensive quality as of itself to mark the nature of conditions.) These crusts begin to fall about the fifteenth day leaving scars and pits which are at first a dark red, gradually becoming lighter and finally a shining white. This briefly constitutes the history of a case of small pox of moderate severity.

Dr. H. D. Wey, City Health Officer, informs me that during the summer and fall of 1898, fourteen cases of small pox developed in the city of Elmira, eight of them before the nature of the disease was determined. In only two was the true pustule, secondary fever and characteristic odor present. The disease was probably brought to Elmira by a boy who came from Groton; the supposition being that he was exposed at that town to some member of the Joshua Simpkins theatrical troupe, who were traveling through Central New York, some of whose members were suffering from small pox, as it was later ascertained, and who were finally placed in quarantine at Geneva.

Of the Elmira manifestations, five of the earliest cases came under my care, three personally and two in association with my partner, Dr. R. B. Howland. My first patient, whose history follows, probably contracted the disease from meeting the boy from Groton on the street, and was the only case known from that source.

CASE I. G. R., age 37, groceryman, was taken ill on July 27th, 1898. Felt as if he had the grippe, ached all over, sense of numbness, very severe backache and headache. Saw the patient first on the morning of the 28th; temperature 103°, pulse 88, severe general aching, no nausea nor vomiting, no chill nor chilly sensations. Diagnosis grippe, as at the time there were a number of cases of that disease in the city. Appetite good, as it was all through the illness, prostration not pronounced. On the 29th, all symptoms better, temperature nearly normal, still some headache and general aching, was dressed and down stairs. On the 30th found him free of fever and feeling

very comfortable, noticed a slight reddish brown papular eruption on the forehead near the hair line. August 1st was dressed and around the house, no fever, pulse normal, papular eruption extended over the face and on body and extremities, papules isolated and increased in size, seemed like small peas bedded into the skin. August 2d. Felt perfectly well and went to his father's, some six miles in the country, where he remained until August 11th, when he returned home.

During the time he was in the country he felt perfectly well and worked each day in haying and other farm work. Before leaving there he came in contact with at least ten different people, beside his family, consisting of his wife, two children under twelve, and a young lady boarder. No history of satisfactory vaccination in his case; wife never vaccinated, other members of his family properly protected.

While in the country he informs me that he came in contact with at least seven people, including his parents, who had never been vaccinated.

On the 11th of August, he returned home and resumed work in his store. On an average at that time, one hundred different people came to his place of business each day.

On August 13th he attended a large picnic at Eldridge Park, where he came in contact with a great many people. At this time the papules were off his face but some remained on his body and extremities. These papules would shrivel up and could be easily removed with the finger nail, leaving a dark reddish stain even with the surface of the skin. No diagnosis was made after the appearance of the eruption, as I knew of no disease presenting the appearance and attending symptoms. It resembled more a papular syphilide, but knowing the patient very well and by direct questioning, it had to be excluded. There was at the time no history of exposure to any contagious disease, he had not been out of the city and had regularly attended to business in his store.

CASE 2. Mrs. G. R., age 35, wife of Case One. On August 13th, 1898, suffered from headache and felt generally used up, went to bed in the afternoon, felt chilly, slept fairly well that night.

August 14th. Ached terribly all over, chilly sensation but no chill, very severe headache and pain in back, no sick stomach or vomiting. In my absence from the city, Dr. J. D. Easton was called. Fever not high, temperature not taken, diagnosis grippe.

August 15th, patient seen by Dr. Easton. All symptoms improved, less fever and general aching.

Saw the patient on the 16th, said she was much better, still some headache, no fever, pulse nearly normal. On the evening of the 16th, the same papular eruption as in her husband's case began to show on the forehead. This eruption gradually extended over the entire person, and while showing no tendency to run together, was more profuse than in Case One. An examination of the throat showed no involvement.

On the 18th, patient up and dressed, feeling fairly well, suffered some from itching, no fever, papules increasing in size, felt like peas bedded in the skin, papules full and rounded, no umbilication.

On the 19th, Dr. F. H. Flood was asked to see the patient for the purpose of diagnosis, as I had declined to make one. It was evident that he was suspicious of small pox, as he inquired if the members of the family had been vaccinated. When asked by the husband, point blank, "Is it small pox?" he said: "No," but that it was herpes.

On the evening of the 21st, I was again called. (Had not seen her since the 17th), found the papules about the size of a large pea and standing well above the surface of the skin, the papules looked yellowish and appeared as if full of pus, the face was swollen and slightly red, skin itching, slight rise in temperature, patient very nervous and restless. On incising several of the papules, no pus was found but a clear serous fluid. The conditions seemed very suggestive of variola, and, as I had had no previous experience with the disease, further opinion was desired. Dr. J. D. Easton, who had treated a number of cases and who had seen as much of the disease as any physician in Elmira, was at once called in consultation. His decision was that it was not small pox, was not able to make a diagnosis. The next morning, August 22d, I invited the City Health Officer, Dr. H. D. Wey, to see the case. After a thorough examination of the patient, he also agreed with the opinion of Dr. Easton, but declined a diagnosis.

On the 23d photographs of the patient's face and one hand were taken, with reference to future diagnosis.

Patient under observation on the 24th and 25th, papules gradually reducing in size, were not umbilicated, did not rupture or coalesce, no offensive odor, patient about the house and feeling well. On the 28th she went to the country to visit her parents where she remained until the 1st of September, when she returned home and resumed her usual household duties.

On the 7th of September, the greater part of the day and a portion of the following day she spent in the primary department of School No. two, which her young son had just entered. At this date, exfoliation was not fully completed. During the time she was at her home,

some thirty people saw her. How many were properly protected by vaccination I am not able to state.

The exposure of people to the disease in these two cases was sufficient in small pox of the usual type, to have produced a widespread epidemic. What was the result? Case one conveyed the disease to his wife only. Case two to but three other persons. To convey the malady seemed to require a long continued exposure in the presence of the patient. It was feebly contagious and apparently not at all infectious. In the three other cases referred to the course pursued by the disease was so very mild that the patients were practically well after the first two or three days. In one of them, the eruption developed itself on the body and arms first, almost entirely, only one or two papules showing on the face. A case which developed early in October presented a type which was believed to be small pox as the severity of the illness was much more pronounced, pustulation and secondary fever being present. Dr. Curtis of the New York State Board of Health was sent for and confirmed this opinion. He also examined the previous patients and decided that all had had small pox. The case seen by him October 14th was quarantined at his home, as were all subsequent cases at their respective places of residence. This method of preventing the spread of the disease as compared with the antiquated city, town or locality pest house, which should be relegated to the dark ages, I can most cordially commend. The infected house was placed under the care and control of guards employed by the Health Board and no one other than properly authorized persons were allowed to enter or leave the house, the inmates being obliged to remain indoors until the quarantine was raised. In no instance was there any extension of the disease where this measure was put in operation.

As a brief review, it will be observed that the cases described presented, as characteristic of small pox, the time of incubation, the headache and backache in a much modified degree, the eruption appearing on or about the third day, the type of eruption and the usual location where it first appeared, the course of the eruption in development and extension up to the period of pustulation.

Its atypical character is apparent in a general way in the lack of the usual violent, prolonged and dangerous features commonly present, and particularly in the absence of: severe chill at the onset, the high fever continuing till the eruption appears, the sick stomach or vomiting, the extreme prostration, the lesion showing on the mucous membranes, the true pustule (in place of which is a sero-papule), of umbilication, of secondary fever, of the characteristic odor, of all the violent, painful and dangerous symptoms usually found after the development of the eruptive stage, and in the marked feebleness of contagion.

In place of a disease of such severity as to be dreaded is one so simple and trivial in most of the cases as to be of no more consequence than would an ordinary case of chicken pox.

NOV 1915
J. F. B.

THE POLLUTION OF PUBLIC WATER SUPPLIES.

W. H. HODGE, M. D.
NIAGARA FALLS.

It has been truly said that pure water is the prime essential of sound individual and public health, while polluted water, on the other hand, is believed to be the cause, direct or indirect, of many of the ailments that afflict, weaken or destroy human life.

From remote antiquity the highest value has been placed upon a pure and abundant water supply, and cities were built in ancient times around those places where it was readily available; there is abundant evidence also that the ancients possessed a keen appreciation of the dangers lurking in a polluted water supply. Enormous and costly aqueducts, reservoirs and conduits were constructed, the ruins of many of which may be seen to this day.

Hippocrates wrote upon the value of pure water and the importance of boiling and filtering it when polluted over two thousand years ago, and Pliny, in his Natural History, written A. D. 70, devotes considerable space to the discussion of potable waters and of the numerous supplies of Rome which he considered the purest and best in all the world. The ancient city of Carthage was supplied with drinking water from a spring sixty miles distant, carried by a conduit which in its course cut through mountains by tunnels and crossed valleys by massive aqueducts.

The relation between drinking water and disease.

Let the health records of any city be examined and it will be invariably found that a notable improvement in the mortality rate has invariably followed the introduction of a water supply that is free from contamination by sewage. Local epidemics of zymotic diseases, especially typhoid fever, are occurring constantly in which the pollution of a public water supply with infected discharges has been proven beyond any reasonable doubt to be responsible for the outbreak. The city of Vienna was for years supplied with water from the Danube River, a stream polluted by sewage, and the mortality from typhoid was very high; some years ago the city was supplied with pure spring water, uncontaminated by sewage or refuse of any kind; since the use of pure water, according to Prof. Nothnagle, typhoid has become such a rarity that when by chance a case appears at the hospital it is shown to the students as one of unusual interest, and he adds that the large proportion of cases now seen come from outside the city.

The outbreak of Asiatic cholera at Hamburg, Germany, in 1892, in which 17,020 were attacked with the disease and 8,605 died, the enormous mortality of over fifty per cent. was traced directly to a contaminated water supply, those portions of the city which were furnished with water uncontaminated by sewage, escaped the plague. It is worthy of note in this connection that not a single case of cholera originated in the hospitals during this epidemic, not one of the per-

sons contracted the disease from the cholera patients with whom they were forced to associate; all this points to the fact that cholera is not contagious, but is conveyed like typhoid in infected water.

The English Rivers Commission, after a most careful and exhaustive investigation of sewage polluted water supplies concluded, first, that the existence of specific poisons capable of producing typhoid fever and cholera is attested by evidence so abundant and strong as to be practically irresistible, these poisons being contained in the discharges from the bowels of persons suffering from these diseases; and secondly, that the admixture of even a small quantity of these infected discharges with a large volume of drinking water is sufficient for the propagation of those diseases among persons using such water. The conclusions of this commission remain unaltered to-day by any recent addition to our knowledge concerning the impurities in water.

It has been estimated that not less than one hundred thousand human lives are lost annually in the United States by death from preventable disease and that a great proportion of this number is due directly or indirectly to the use of infected water supplies.

For years the question of water pollution has engaged the attention of the best sanitary scientists of the day, and there can be no doubt that the consideration of this question dwarfs all others into comparative insignificance. The old idea that running water becomes purified has long since been shown to have been entirely erroneous; I believe that water once polluted by sewage should never again be used for human consumption, since the most efficient artificial filtration leaves in water much invisible matter in suspension and constitutes no effective safeguard against the propagation of disease.

So great a nuisance has the pollution by sewage of public streams become that government aid must be invoked and a national law enacted, prohibiting the emptying of sewage or refuse of any description into any body of water that is used for human consumption; the necessity of this law being national is apparent, for one stream of water may flow through many different States, thus rendering a State law of little value.

No legislation could be enacted that would be the means of saving so many human lives and it would forever remain as a fitting monument to the highest civilization of the nineteenth century.

HYGIENE OF CONSUMPTION.

BURT J. MAYCOCK, M. D.,
BUFFALO.

Although I have nothing especially new to say on this subject, yet when we consider the laxness with which the disease is looked after, the enormous numbers that die each year from it and the fact that it is a disease which is infectious, preventable to a very large extent and curable in a fair proportion of cases, the necessity of harping on it is readily seen.

It is estimated that from one-fifth to one-seventh of all deaths are from tuberculosis. At least 5,000,000 people die of it each year. In New York State alone there are about 14,000 deaths annually from this one disease. If one-tenth of this number were to die of cholera there would be a hue and cry which would compel decided action to be taken. But people are used to having their friends and relatives contract and die of tuberculosis, and like the Mohammedans, stand idly by and say "It is the will of Allah."

Yet, with proper precautions, there is no doubt but that in a decade the death-rate from consumption could be reduced at least one-half. And I am here to-day to urge upon the members of this Society the necessity of their instructing more carefully their patients with this dread disease, not only as to their care of themselves, but as to the protection of their friends. It is a duty which we, as physicians, owe to society that we faithfully perform our larger duties as preventors of disease and not merely as healers, and thus live up to our title of doctor—meaning teacher.

There is every reason why strong efforts should be made to reduce the prevalence of this plague. Looking at the subject from the most sordid standpoint, the question of cost, we see that it would pay the State to make even a very large immediate outlay, for the investment would pay a very handsome return. By far the greater number of deaths from pulmonary consumption occur between the ages of 15 and 45. In other words, just at the age when the citizen is of most value to the State, when the expense of his education and care has been paid and when he should be producing something by his own labor. And we must bear in mind that the typical consumptive is bright, quick, intelligent, hopeful, with a highly sensitive, nervous system—one who works with his brains, and consequently of the greatest value to the community.

Owing to the long period of incubation and the relatively small proportion of the community who, under ordinary circumstances, become infected, it is only within late years that the infectiousness of tuberculosis has been recognized.

But if the direct relationship between the tubercle bacillus and the tubercle be accepted, it follows as a logical sequence that without infection there can be no tuberculosis, and that in every case the disease must be either congenital or the result of infection. Heredity plays a much smaller part in the process than we formerly supposed and is very largely limited to a weakened resistance against the disease —possibly against any infectious disease.

While under ordinary circumstances the resisting power of the individual depends upon his general constitution and his state of health at the time of exposure, yet it is probable that every individual, no matter how robust his health, is susceptible to the disease provided the dose of virus is sufficiently large.

The possible sources of infection are the air breathed, the food taken into the body, and inoculation. As the most frequent location of tuberculosis is in the lungs and bronchial glands, the usual mode

of infection is probably through the respiratory passages and infected air is the vehicle.

As the expired air in cases of pulmonary tuberculosis is free from bacilli, the sputum must be the carrier. Cornet was the first to show that the bacillus is carried in the dust of rooms inhabited by tuberculous patients.

It is only necessary to thoroughly disinfect the sputum in all cases to diminish enormously the number of patients with this disease. If we can go further, and send every consumptive to a special locality and keep him there, why can we not wipe out the disease as cholera has been wiped out of this country? If cases are diagnosed early and sent, say, to a hospital in the Adirondacks, it would not only prevent the spread of the disease but offer a good chance of cure.

The results obtained at Goebersdorf show that out of 1,390 cases in the first stage of the disease, 27.8% were cured and 31% nearly cured; making a total of 58.8% practically cured. These figures cover the years from 1876 to 1886 and sufficient time has elapsed to show that the cure was permanent.

The results obtained at present at Nordrach are said to be even better than this.

With as hopeful a prospect as this before them, consumptives ought no longer dread having a diagnosis made, but if made to understand the matter would probably prefer an early diagnosis as giving them a better chance for recovery. The tendency at present is to regard a diagnosis of consumption as practically a death warrant, and consequently is not looked forward to with anything but horror.

It is a law of civilized life that anyone subject to a communicable disease must adopt all measures known to prevent its spread to others, and it is the duty of the medical profession to urge tuberculous patients to take all necessary precautions to avoid the possibility of transmitting the disease. To this end promiscuous spitting should be absolutely prohibited. The tuberculous patient should expectorate only into a disinfecting solution or a pocket handkerchief which should be thoroughly disinfected before being sent to the laundry. Preferably they should carry flasks or spit-cups in which is a disinfecting solution.

All their eating utensils should be washed thoroughly in hot water to which washing soda has been added, and afterwards placed in boiling water for at least two minutes.

They should be warned against swallowing the expectoration in order to prevent other organs becoming affected.

As there is a constant effort made by every organism to throw off disease, we should aim to increase the resisting power of the individual and thus aid in the struggle. The most important object to be kept in view is the maintenance of nutrition. If the patient can grow fat he is safe. With this end in view he should be fed vigorously—three good meals a day, with nutritious interludes.

A life in the open air aids digestion, and is of far more benefit generally than the old system of coddling.

This plan of treatment as followed in Germany, notably at Goebers-

dorf, Falkenstein and Nordrach, keeps the patient in the open air at least ten hours a day. The constant aim is to have as little difference as possible between the outer air and that indoors. Colds are practically unknown and the results obtained are excellent.

Last year there was a bill introduced in the Legislature of this State providing for a State hospital on the pavilion plan in the Forest Preserve of the Adirondacks. That bill is still in committee. But it should be passed, and I wish that this Society would instruct its Committee on Legislation to use its influence to further the passage of this bill.

Massachusetts has recently opened a State hospital for consumptives at Rutland, and other States are looking toward the same thing.

This bill provides that patients in destitute circumstances should have the preference. This does not mean necessarily a large increase in taxation, but a re-distribution. As it is now, we care for destitute consumptives in our poor houses and county hospitals, where they stay until they die. Under this bill they would be cared for by the State in their early stage until they get well. The patients would average perhaps a year at this hospital and could be returned to their families and take their places again as bread-winners.

So the people of the State would have one person to support for a year at a cost of about $250 and perhaps his family to support in the meantime. As it is now we support the patient for about the same length of time when he is dying, and support his family not only during that time but for an indefinite time after.

To be sure this is only a start in the right direction, but a start is better than standing still, doing next to nothing while the great white plague stalks unmolested through the land.

REPORT

OF THE

BUREAU OF CLINICAL MEDICINE.

CHRONIC SEMINAL VESICULITIS AS A CAUSE OF SEXUAL DISORDERS IN MEN.

E. H. NOBLE, M. D.,
ELMIRA.

The purpose of this paper is suggestive. The excuse for its presentation is that in homœopathic literature but one reference to this, in the writer's experience, important subject has come to his notice and that a mere passing allusion.*

*Since the above was written, there has appeared from the pen of Dr. Bukk G. Carleton an excellent work upon "The Sexual Disorders of Men," in which the subject of chronic seminal vesiculitis is most thoroughly and admirably treated.

It is undoubtedly a fact that sexual disorders in men are much more frequent than the number of patients applying to the profession for relief would lead us to believe. Many men go through life suffering from troubles of this nature because a false delicacy leads them to conceal them. The courageous few who do seek aid from the legitimate practitioner in too many instances fail to obtain the assistance they desire. It would seem in these days of medical progress that this should not be so, and that it is so we believe to be due to two reasons. First, that the profession as a whole have devoted but comparatively little attention to this class of diseases, and second, some important pathological conditions have hitherto escaped detection as a causative factor of sexual disturbances.

A study of the disease mentioned in our title we believe to be a step in the right direction, and the thanks of the entire profession are due Dr. Eugene Fuller, of New York, for his investigations along this line, and to whose work the writer is indebted for many valuable suggestions for this article.

In order to understand the nature of seminal vesiculitis and its treatment, it will be necessary briefly to remind you that the seminal vesicles are two sacs composed of fibrous, muscular and mucous tissues, richly supplied with gangliated nerves, situated on the posterior walls of the bladder, the function of which is to store the seminal fluid and discharge it during the copulative act. They are directly connected with the urethra by the seminal ducts, and with the testicles through the vas deferens. When chronically inflamed (for the acute form of seminal vesiculitis is not within the scope of this paper) these structures become greatly modified. The muscular tissue loses its tone and as a consequence the sacs become distended and unable to discharge their contents, the walls become inelastic and unyielding and the perivesicular tissues infiltrated. The mucous membrane being changed, their contents are modified. The seminal fluid becomes thickened and gelatinous, and often contains pus and blood.

Three forms of vesiculitis have been classified, simple, gonorrhœal and tubercular.

The simple form is the most rare. It is caused by sexual excesses, especially at an early age, masturbation, perversions of the sexual act, and occasionally by prolonged abstinence from sexual indulgence. General debility from constitutional disease and nerve weakness give origin to seminal vesiculitis. Careless or inappropriate treatment directed to the deep urethra is frequently a cause.

The gonorrhœal form, which is by far the most frequent, is due to direct extension of an acute gonorrhœal inflammation to the vesicles which become chronic, or it may be a gradual invasion of the vesicular substance by latent gonorrhœal infection.

The tubercular form is generally secondary to tubercular disease elsewhere, although it may be primary.

The symptoms attending chronic seminal vesiculitis are many and varied. Indeed, they embrace that wide range of deviation from the normal standard which every physician is familiar with as belonging

to victims of sexual disorders. We will, therefore, only call your attention to those symptoms which seem more frequently to accompany sexual weaknesses caused by the disease under consideration. These are of two kinds, local and remote. Of local symptoms those which we would naturally expect to find, namely, symptoms of inflammatory action, are more commonly absent. When present, they are those of a mild type. The pain is usually reflex, locating above the symphysis pubis or in the rectum. It is induced or aggravated by sexual excitement. Tenderness usually appears in the rectum, is aggravated by defecation, and leads the victim to think he is suffering from hæmorrhoids or some rectal disorder. Occasionally it may appear in the perineum.

Still more pronounced is the effect of seminal vesiculitis upon the sexual function. Here we find all grades of diminished sexual force, even to complete impotence.

Spermatorrhœa is generally present so long as the vesicular walls retain enough tone to expel their contents. Later, they may become so weakened as to be unable to empty themselves, even during intercourse. If the ducts also become atonic, a more or less constant passive seminal flow becomes a feature of this disease, although its seminal character is lost. It is always well to bear in mind, when treating cases of chronic urethral discharge which do not readily yield, to investigate the condition of the seminal vesicles.

Chronic seminal vesiculitis is generally accompanied by a variety of abnormal sensations in the genital organs. The penis feels cold, numb and shriveled. The testicles have a dragging, relaxed feeling as does also the scrotum, though less frequently, the scrotum may be retracted. In one of the author's cases it was persistently and painfully so.

Neurotic sensations in the urinary tract are not infrequent. The vesical neck may be affected and simulate a mild attack of cystitis or irritable bladder. Sometimes they may locate in the urethra, causing a burning, during micturition, throughout the entire urethral canal. One of my cases described what seemed to him to be a raw spot which was located just back of the frænum and which was painfully sensitive to the urinary flow. Investigation of course showed the urethra to be healthy. The condition was speedily relieved by appropriate treatment to the vesicles. Extension of inflammation to the epididymus is of very common occurrence during vesiculitis.

The urine of patients suffering from seminal vesiculitis may contain pus and blood, which has escaped from the diseased vesicles into the urethral canal and has been washed out by the flow of urine. The urine of these patients, also, is apt to be phosphatic and to contain calcic oxalate.

It would be futile to enumerate all of the remote symptoms resulting from chronic seminal vesiculitis, though they are very distressing to the patient and form an interesting study. They consist of headaches, neuralgia, disturbance of the digestive tract, buzzing and ringing in the ears, numbness of the extremities, alternate sensations of

heat and cold, hyperæsthesia and anæsthesia of parts of the body and hysterical manifestations. These have all been cured through treatment of the seminal vesicles.

The mental sphere perhaps presents the most distressing, if not the most alarming, conditions. These patients are nearly always melancholy in character, varying from simple lassitude and indisposition to mental or physical exertion to even suicidal tendencies. Shyness of women and dislike for society are mental conditions nearly always present to a greater or less degree. Irritability of temper has been a marked characteristic of some cases. Insomnia is nearly always present. Some cases of sexual perversion have been traced to this disease. In fact, almost any symptoms of mental and nerve depression may accompany seminal vesiculitis. The writer believes it a duty incumbent upon every physician to examine the vesicles in all protracted cases of male neurasthenia coming under his care.

Diagnosis.—It is extremely important to differentiate between seminal vesiculitis and other causes for sexual weakness, as instrumentation of the deep urethra, such as employed in strictures of large calibre after the method of Prof. Gross, injection of astringents into the prostatic urethra for supposed posterior urethritis, etc., are extremely prone to aggravate chronic vesiculitis and to produce an acute epididymitis. From what has already been said it is very evident that seminal vesiculitis may resemble a great variety of conditions. The positive diagnosis of seminal vesiculitis depends upon the educated finger of the examining physician. Upon inserting the finger into the rectum (the patient having been careful to have allowed his bladder to become full) the seminal vesicles, which in the normal state are almost if not quite impalpable, will be felt as enlarged, indurated, pear-shaped masses, somewhat doughy to the feel, from which by gentle pressure the morbid contents may be expressed and examined. The vesicles will be left in a more or less collapsed condition, depending upon the amount of thickening present in the vesicular walls. The vesicles will usually be found tender to pressure, often exquisitely so.

Prognosis.—The prognosis depends upon the age and constitution of the patient, the duration of the disease and its character. Of the three forms, the tubercular is the least amenable to treatment. Of other forms, in patients of fair constitution, under forty years of age, the prognosis is as a rule favorable. After this age, the chances of restoration to sexual vigor decrease with advancing years, and though we may not be able in all cases to restore sexual force, we are quite safe in promising relief from a great many of the distressing phenomena attending seminal vesiculitis.

Treatment.—It is probable that many cases of chronic seminal vesiculitis recover without any treatment directed locally to the vesicles. In fact, our knowledge of this disease in its relation to sexual disorders is so recent, and observation upon these cases so comparatively limited, that we have no foundation upon which to base an estimate of the results obtained from purely medicinal treatment. Without doubt, however, sexual abstinence, forced nutrition, tonic

treatment, etc., which has so long been the established treatment for sexual weaknesses, have cured many cases of seminal vesiculitis. Homœopathic materia medica is rich in remedies which cover the symptoms presented by this disease, and which undoubtedly have cured many cases. There are, unfortunately, a certain percentage of cases that will not recover by these measures. In these, no treatment yet known is comparable to that introduced and employed by Dr. Fuller of New York, to whom reference had already been made, and to which he has given the name Stripping of the Vesicles. It seems a most rational way of dealing with the conditions presented. We have an atonic muscular sac, filled with a morbid secretion, without means of drainage. The treatment about to be described relieves the vesicle of its irritating contents, and the manipulation employed acts as a gentle massage to the muscular tissue, increasing its strength and restoring its tone. The method is very simple of comprehension but rather difficult of employment, because to successfully strip the vesicles requires an education of the tactile sense almost equal to that necessary in successful gynæcological practice. After having acquired the ability to map out and palpate the vesicles, the treatment employed is simply to introduce the finger into the rectum, reaching up on the body of the vesicle as far as possible, to gently depress the tip of the finger from the first joint upon the vesicle, then slowly withdrawing the finger, following the vesicle with its tip, express the contents into the urethra. This will immediately appear at the meatus, and can be caught for examination. Each vesicle should be stripped by this method four or five times. At first the vesicles are usually extremely sensitive, and if too great violence is used or the strippings are performed too often, a reaction follows which may cause the patient some discomfort and even excite inflammation in the epididymis. From four to seven days is the length of time which should intervene between the treatments. As time passes, it will be found that the sensitiveness of the vesicles gradually diminishes, the contents of the vesicles improves in quality, and the substance expressed decreases in amount until finally it disappears entirely. By this time the induration about the vesicles will have nearly if not quite disappeared, and the patient will be cured. To perform this treatment it is necessary that the patient should present himself with the bladder well filled, in order to form a point of resistance upon which the vesicles may rest, which can be farther sustained by pressure made above the symphysis pubis by the free hand of the surgeon. Dr. Fuller emphasizes the free use of cod liver oil in connection with this treatment, as of great assistance in absorbing the products of inflammation. This is in brief, the most successful treatment for these cases extant to-day, and if this paper shall have excited any interest in this subject on the part of its hearers, we would earnestly recommend them to the careful study of Dr. Fuller's work, which is the only one known to the writer which is a comprehensive treatise on this subject. (See foot-note at beginning of this article.)

Two cases of this disease have occurred in the writer's practice.

The first, a young man of twenty-five, who had become completely impotent. His condition was truly pitiable. He was incapable of mental or physical exertion, at times was in a condition of extreme melancholia, and had more than once seriously contemplated suicide, suffered extremely from anthropophobia, would oftentimes cross the street to avoid meeting even intimate acquaintances, and had been obliged to break his engagement with a young lady because of his sexual condition. This young man had been treated by physicians and specialists eminent in both schools, and his condition had been diagnosed as sexual neurasthenia, posterior urethritis, and in fact most everything known to result in impotence. He had received all kinds of treatment, general and local, medicinal, surgical and electrical, without benefit, when he came to my hands. This young man gave a history of masturbation in early life, in moderation. He had, at the time of puberty, some severe constitutional disease, the nature of which I am unable to state, and from that time his disorder seemed to date. He had never contracted gonorrhœa nor suffered from spermatorrhœa. The disease seemed to expend its force in the nervous system. In fact, there was total absence of local symptoms, except his loss of sexual power and, on three or four occasions, the occurrence of sharp pain located at the anterior anal border. A few weeks after he came into my hands he discovered that after the passage of a hard stool there often appeared at the meatus a gelatinous substance. This was obtained, and upon examination with the microscope was discovered to consist of dead spermatozoa, pus and blood, and other detritus. Soon after this an attack of acute epididymitis occurred for which there was no discoverable cause, and this was followed by severe irritation at the vesical neck. At this time my attention was called to Dr. Fuller's work, I obtained it, and was convinced by these conditions that I had to deal with chronic seminal vesiculitis. In my own inexperienced way, I confirmed my opinion by an examination of the vesicles, and to be sure sent my patient to Dr. Fuller for examination. My diagnosis was confirmed by the doctor, although the extreme pain produced when the finger came in contact with the indurated vesicle upon my first examination was sufficiently convincing. Suffice it to say, under treatment by the method outlined this patient's general health greatly improved, his extreme nervousness and melancholia gradually vanished, and his sexual power slowly returned.

My second case was that of a man over forty years of age, who has for several years been partially impotent. This fact caused him no annoyance, and it was not until a more or less constant discharge, together with a frequent desire to urinate (the urine causing severe burning as it passed over what seemed to the patient a raw spot in the urethra), that he applied for treatment. He was also afflicted with annoying erections, which occurred without respect to time or place, unattended by erotic sensations. Examinations showed the vesicles to be indurated and inflamed, and pressure expelled the characteristic discharge of seminal vesiculitis. Systematic treatment was resorted

to and resulted in prompt relief from the conditions named. This man is not yet cured, nor will his sexual power ever be restored. His age is not in his favor, and his constitution is impaired by an almost total destruction of one kidney by pyelitis.

REPORT

OF THE

BUREAU OF SURGERY.

OFFICE TREATMENT OF FISTULA IN ANO.

E. F. HOYT, M. D.
NEW YORK.

To rescue the treatment of this condition from as many of its objectionable features as possible has been the ambition of many surgeons, yet the question remains an open one to-day, various methods finding endorsement from various practitioners. With an experience based upon about one thousand cases, I have sifted the subject in all of its different relations and arrived at a conclusion that seems quite satisfactory as to simplicity and success. It is impossible, even after a complex research, to ignore the central principle involved in the original proceeding of dividing the walls of the sinus, though just how this should be done comprises the complete consideration of this subject. I am thoroughly impressed with the conclusion that any suggestion at variance with this idea is not worthy of the slightest attention. There is not a principle in surgery or mechanics but that can be simplified and improved by the protracted application of a practical mind devoted exclusively to any particular purpose.

A patient suffering from fistula is always anxious to get well with the least possible delay, and is especially timid as to anæsthetics and the indefinite period of detention from active life, not forgetting certain enervation that always follows these experiences. Now it is a very easy matter to manage one of these cases by first injecting cocaine, so as to get its effect for about one inch parallel to the outer extremity of the sinus, then introduce the grooved director, after which divide the fistula so affected. Then with a double bulbed atomizer, filled with electrozone, throw a continued spray into the wound for one minute, holding the nozzle about four inches away from point of contact. There is something peculiar and very satis-

factory in the action of this antiseptic, as it renders the parts free from that sensitive soreness that naturally would be expected, allowing the patient to continue the routine of daily life without inconvenience. The first dressing after the incision consists of packing firmly with iodoform gauze, supported by a T bandage. Subsequent daily dressings do not require anything except the above mentioned spray and a small piece of gauze placed in position loosely and held by usual bandage. In about every three to ten days another inch can be divided, and so on until the end is reached. If there are any branches they always show themselves, as their point of union refuses to heal with the general result, so it is impossible to overlook any diverging issue.

It is easy to note how about three minutes daily attention can secure such prompt resolution in these matters. All of these patients present a cachectic appearance, reduced vitality and all the concurring symptoms of a general septicæmia on account of the slow absorption of the specific poison. From the very beginning there is a healthful reaction, as the impaired circulation attains its normal condition in consequence of the infection being discontinued. There is always a gain in weight from five to twenty pounds during the treatment, which surely is not true of hospital practice. This method is not applicable to those cases where there is a large amount of cellular tissue involved, as in the instance of very large people. With these I use the elastic or inelastic ligature, being governed by the conditions existing in each individual case.

REPORT

OF THE

BUREAU OF NEUROLOGY.

"The Psychological Aspects of Grief," - - SELDEN H. TALCOTT.
"A Suggestion in the Treatment of Tremor," GEORGE FRED. LAIDLAW.

THE PSYCHOLOGICAL ASPECTS OF GRIEF.

SELDEN H. TALCOTT, A. M., M. D., PH. D.,
MIDDLETOWN.

It is the duty of the members of the Bureau of Mental and Nervous Diseases to make, from time to time, contributions in psychology to this Society. At the present time, we shall endeavor to offer briefly a few of the psychological aspects of grief.

Grief is psychalgia or soul pain. It is the antithesis of joy or happiness. Grief is one of the universal afflictions of mankind. Its existence dates back to the expulsion of our first parents from Eden. Its effects have found lodgment, to a greater or less extent, in the hearts of all humanity down to the present time; and yet, as the world moves on, the forces of grief will be expelled from the souls of men, and the forces of delightsome joy will march in to take their places.

Recognizing grief as an important factor in all human experiences, it seems to me that we should consider, now and then, the causes and the conditions of this depressing and degenerating emotion. The object of such a study should be the discovery of remedies which will tend to relieve this sad state of the oppressed human soul.

We find the causes of grief in every adverse condition in life. We see the pain of sorrow upon the faces of children who have been the victims of neglect, of abuse, of poverty, of rags, and of insufficient and unwholesome food. In its subtler forms, we find causes of grief in a lack of opportunity to get an education, in a disappointment in the gratification of æsthetic tastes, in the benumbing of the ambitious impulses of youth. In mature life, we see expressions of grief upon the countenances of those who have met with and been over-borne by the forces of oppression, and tyranny, and wrong. We see grief tracing its lines of premature old age upon the faces of those who have experienced a loss of friends, a sweeping away of property, a defeat in political aspirations, a disappointment within the sacred realms of love.

Again, grief finds expression in those who have suffered from depletions of the body, through mal-nutrition or mal-assimilation; or in those who have experienced the shocks of either physical or mental disease. The impairment of bodily functions throughout the digestive tract produces semi-starvation and anæmia of the brain. This robs the human being of power to fulfill his mission in life. Without strength there can be no achievement, and when the body is bent or broken by disease, the spirit feels the effects of prostrating and benumbing grief.

Physical disease is often a cause of grief; on the other hand, the shock of misfortune, as felt by the mind, often tends to produce physical degeneration. Grief is the shuttlecock of disaster that runs back and forth through all the warp and woof of life. It leaves a trail of sombre tint which is as clear and unmistakable as the red thread that runs through all the cordage of the British Navy.

Again, grief finds its way to the human soul through the commission of crime, and the remorse which sometimes follows the performance of unlawful actions. Grief may also enter the human heart through brooding over the unchangeable experiences of the past, or the disturbing environments of the present; and, worst of all, grief finds itself yoked with those anxieties which, through unfortunate and unwise teachings, trouble the souls of men as to their future prospects. It has been said that "the fear of the Lord is the beginning of wisdom," but fears of future punishment, which are sometimes con-

jured up in the minds of children by torturing teachers, too oft, alas! develop a grief in youthful hearts which is as disheartening as the prophecies of Poe's raven.

We have presented a few of the general causes of grief. They represent physical, mental and spiritual misfortunes. All men are subject to disappointments, and losses, and anxieties concerning past and future events. The common disasters and unfortunate beliefs of life are productive of that lurid-tinted emotion known as grief.

The ordinary expressions of grief are those of tears and lamentations. When grief is carried to its ultimate, we have a condition known as despair. A grief that will lead to utter despondency and desolation of soul in one person, will be borne with philosophical fortitude by another. There are some instances of noble and exalting grief in the world. Job was afflicted with boils on his body, and the shock of losses in his soul. The Healer of Galilee was "a man of sorrows, and acquainted with grief." Abraham Lincoln was the victim of a settled and long-lasting grief, brought on through disappointment in love while he was yet in the vestibule of manhood. Job in the midst of his grief developed a masterly patience. The grief of Him who sorrowed over the afflictions and distresses of humanity was a grief borne with such noble fortitude that it became a heavenly inspiration. Lincoln sought to antidote his griefs, and likewise to relieve the griefs of others, by injecting into the words and actions of his daily life the tincture of perennial mirth. These examples of patience, and fortitude, and fun are worthy of imitation by all those who are called upon to endure the ordinary and extraordinary afflictions of life.

We speak now of grief, and the wisdom and advisability of getting away from it as fast as possible, because if grief is allowed to settle and stay in the human heart, then insanities, with delusions and despairs, are sure to rise up, and flourish in all their exuberant hideousness in the garden of the human soul. Men are crazed with grief from many causes. Chief among the griefs which produce insanity are those which come from sudden shock of pain or loss, and the wounding of pride, or mental suffering through false accusation.

Having considered the causes of grief, and the conditions which exist when grief permeates the soul, we should look for those remedies which are most likely to effect a satisfactory cure or relief.

In the first place, all teachers should disseminate a knowledge of the value of optimism. Every human being should be taught the necessity for looking upon the bright side of things as a psychological benefit. Each one should be taught to develop the art of caution, and avoid as far as possible needless disasters. Having minimized misfortune by caution and care, then we should cultivate a spirit of fortitude, and learn to endure with patience such afflictions of life as may chance to come our way. A knowledge of the truth, and its willing acceptance; a study of caution, and the avoidance of misfortune by reasonable means; and uncomplaining endurance of that which is inevitable and unavoidable, are the true psychological principles upon which we should base our action and feeling in life.

And again, we should crown our worldly wisdom and our optimistic views with the bright and glorious halo of a much-enduring faith. "Faith is the substance of things hoped for, the evidence of things not seen." The faith of the new psychology is the faith of the eleventh commandment. The old rules of life were restrictive. The new rule of life is a rule which, if implicitly followed, will lead us away from present trials and cares and tribulations, and from future brimstone! The old rule was: "Thou shalt not;" the new rule declares: "Thou shalt." One restrains from sin; the other impels to love for God and one's neighbor. Under the old law there was fear; under the new law there is love. The psychological tendency of the times, while still hindered by much that is old and effete, is steadily marching toward the light and glory of the millennial morning.

It may be the minister's function to relieve the effects of sin upon the human soul by offering the rich sympathy of religious consolation. It is the duty of the physician to relieve grief by curing the ailments and the distresses of the body and the mind. The great Healer of Gennesareth offered to the victims of grief and overwear the blessed boon of rest. "Come unto me, all ye who labor and are heavy laden, and I will give you rest" was the treatment which He offered to those who were emaciated in body, and anxious in mind. Coupled with rest, we should offer such food as will most surely nourish and recuperate the exhaustion of the worn-out body, and with renewed strength of the body comes renewed hope and aspiration to the human soul.

Above all, we may offer to those who need most efficacious help the blessed potencies of homœopathy. If Dr. Gallavardin, of Lyons, France, can cure, with homœopathic remedies, those evil propensities and unwise passions which fill the hearts of men at times with bitterness, and provoke them to gluttony and crime, why may we not cure the griefs of humanity by the administration of

> "Many simples operative, whose power
> Will close the eye of anguish"?

We have been able to test some homœopathic remedies in this direction, and we find that when properly applied these medicines, whose use was disclosed by the immortal Hahnemann, are as effective in relieving mental distress as in curing physical disease.

We present the characteristic indications of six remedies for the cure or amelioration of human griefs. They are as follows:

Arsenicum. Arsenicum is a remedy which is useful in cases of grief after business reverses or mental over-exertion. The arsenicum patient fears that some great calamity is about to overtake himself or his family. He is restless and anxious; despairs of life, and often becomes suicidal, trying to kill himself, or to mutilate his body. The grief of the arsenicum case is evident to all, as his mental perturbation and restless anguish do not allow him a moment of tranquil quiet. The arsenicum patient is driven from place to place in search of relief, and on account of the restlessness and anguish he quickly emaciates and becomes a living skeleton.

Ignatia. The ignatia patient is full of suppressed grief due, perhaps, to some imaginary crime, to some slight reprimand, or to disappointment in love; the loss of dear friends or beloved objects. This grief is nourished in solitude, feeding upon itself, and any effort to draw out the patient finds her taciturn and moody. Women are more subject to ignatia moods than men. The ignatia patient does not want to talk, but wants to be alone, and desires to brood in some quiet corner; she is averse to amusement in any form.

Natrum Muriaticum. The natrum mur. patient is sad and gloomy and depressed without apparent cause. Such a case seems to revel in its grief, and tries to recall all the disagreeable occurrences of the past for the purpose of indulging in melancholy meditation. Consolation aggravates the condition, either recalling to the mind past sorrows, or arousing concern for the future. Despair deprives the natrum mur. patient of all mental power. He is taciturn, easily offended, avoids society, and thinks he is pitied by every one because of his misfortunes. Above all, the natrum mur. patient weeps profusely and vigorously.

Pulsatilla. The grief of pulsatilla is a changeable grief. The patient (usually a woman) is apt to have alternate moods of crying and laughing. The pulsatilla patient, in her mental state, resembles an April day, when sunshine alternates with rain at frequent intervals. The pulsatilla patient is at times melancholy, and inclined to shed tears; and again, she becomes cheerful, and indulges in outbursts of laughter. The depression of pulsatilla is generally greater in the morning, and the mind recurs at such a time to business or domestic affairs. The pulsatilla patient is gentle and affectionate in her disposition; is mild, and yields easily to persuasion. Consolation is acceptable to such a patient, and, in fact, the pulsatilla case enjoys lively company and good advice.

Stramonium. The stramonium patient is filled with sadness, and apprehends evil consequences from trifling things. He walks about, shedding tears, and uttering loud lamentations. He is inconsolable, and has pangs of conscience because he thinks he is not honest. From a condition of noisy excitement, where he is inclined to become pugilistic, he passes into another state where he is overborne with cowardly fears which arise from frightful imaginings. He sees strange animals on every hand that seem about to tear him to pieces. Hence, in the midst of profound grief for shortcomings, he is beset with abject and horrible fears of personal injury. He tries to escape from the horrible Gorgons by which he is surrounded, and cries out piteously for help.

Veratrum Album. The veratrum alb. patient has depression of spirits, grief, anxiety and apprehensiveness as if she had committed some great crime. The veratrum alb. patient talks a great deal upon religious subjects, despairs of salvation; also thinks that her position in society is jeopardized on account of some evil action in the past. The veratrum alb. patient has sometimes a suicidal tendency from religious despair. She thinks that she has violated her vows to God, and that, consequently, her soul will be eternally damned. The vera-

trum alb. patient is usually an over-conscientious person given to much meditation upon religious subjects, and is addicted to long prayers. The shock of anxiety or fear, as felt by the veratrum alb. patient, tends to the production of physical collapse, and from a state of religious frenzy, anxiety and restlessness, this patient soon comes to resemble, physically, a case of cholera in the stage of collapse.

In conclusion, permit me to state that the consideration of grief is peculiarly appropriate at this time because the nations of the earth are suffering from the after effects of the "grip"; and chief among the sequelæ of that dread disease we find not only a physical prostration, but a mental depression of the kind which typifies every form and phase and fashion of grief. As physicians, we should consider all the tendencies of the times so far as the production of certain forms of either mental or physical disease may be concerned, and then each physician should exercise in his own heart and teach it to others the benign philosophy of optimism. He should encourage those who are tired out and stricken with grief to rest until recuperated. He should give to all who are enfeebled the most effective kinds of meat and drink. He should apply homœopathic remedies selected according to the similium in each case after careful individualization; and, for a final injunction to every patient, he may say with Goethe:

"If thou wouldst live unruffled by care,
Let not the past torment thee e'er;
As little as possible be thou annoy'd,
And let the present be ever enjoy'd;
Ne'er let thy breast with hate be supplied,
And to God the future confide."

A SUGGESTION IN THE TREATMENT OF TREMOR.

GEORGE FREDERICK LAIDLAW, M. D.,
NEW YORK.

The title announced on the programme is too pretentious for this short paper, and I have taken the liberty of substituting the title "A Suggestion in the Treatment of Tremor."

Tremor is a symptom, and has been roughly divided into two classes, essential tremor and intentional tremor. Essential tremor finds its typical expression in paralysis agitans, in which the trembling is continuous during rest but can be controlled by an effort of the will, at least in the early stages of the disease. In intentional tremor, the more the patient tries to control it, the more violent the tremor becomes, as is seen familiarly in neurasthenia and alcoholism when attempting to lift a glass of water to the mouth. In disseminated

sclerosis of the cord, intentional tremor is an early and constant symptom. In nervous diseases of many forms, we notice intentional tremor. I have seen it in simple nervous exhaustion from overwork, fright, sorrow or worry. It is frequently seen in that obscure condition that follows injury to the spine, where the vertebræ remain tender to pressure at the site of injury and we see many peripheral pains, spasms and functional disturbances of the limbs or organs controlled by the damaged spinal area.

In these lighter forms of tremor, no constant pathological lesion has been found; but, in disseminated sclerosis, which exhibits intentional tremor in its most typical form, the pathological changes are well-known. The lesion is located in the white substance of the cord and consists of a liquefaction and disappearance of the medullary sheath of the nerve fibers, the well-known "white substance of Schwann," of the older physiologists. In the microscopic examination of a cross section of the diseased area, whole fields of naked axis cylinders are found. At a later stage, the fibrous connective tissue closes in around the axis cylinders, filling the place of the former medullary sheath and finally the axis cylinders themselves disintegrate and disappear.

I am far from taking the position that because the intentional tremor of sclerosis is associated with a degeneration of the myelin sheath, therefore all other tremors are due to the same change. But I do claim that the absence of definite lesions does not prove that, in the lighter forms of tremor, the myelin sheath is perfectly healthy. Again, in the treatment of disease, the physician must have some theory as a basis for his thinking, even though it is a false theory. If it is false, experience will modify it in the direction of truth. It was with these thoughts in mind that I undertook the cure of a case of old spinal injury. There was no deformity, but many spasmodic and painful symptoms, insomnia and frequent vomiting. The case would be classed as hysteria if one did not know the history of accident. There was marked intentional tremor, especially of the hands, arms and head. I argued that, in this case, the medullary sheath was probably melting away from the nerve fibers in the cord or, if not actually dying, it was feeling very miserable. With the triumphant thyroid therapeutics ringing in one's ears from every side, with bone-marrow, spleen-extract, ovary-extract and Brown Sequard's rejuvenator, making a whole newspaperful of brilliant cures, what was more natural than the thought that if we could feed the patient with an abundance of good myelin, it would benefit the sick myelin-sheaths of the affected nerves. Fortunately for this purpose, we are not compelled to dose the patient with unsavory spinal cords. The yolk of egg contains a large amount of myelin, chemically identical with that of the medullary sheath. It has always seemed to me that yolk of egg was more serviceable when thoroughly cooked than when raw, and the method of administration was to boil the egg for half an hour, discard the white and eat the well-cooked yolk, spread on bread and butter or in any palatable manner. Four to six yolks a day were given. The tremor improved

at once, and the patient recovered. Since that time, I have employed the yolks of hard-boiled eggs as a convenient source of myelin in a number of cases of tremor, and it has seemed to me that I could ascribe a distinct value to the procedure. I have certainly seen tremor which had been unaffected by previous treatment improve shortly after commencing the yolk of egg. One thinks of Weir Mitchell's superalimentation treatment for neurasthenia in which raw eggs are used in large numbers.

Such is the suggestion that I offer.

REPORT

OF THE

BUREAU OF OBSTETRICS.

"Fibroid Degeneration of the Placenta with Malformation of the Fœtus," - - - - - W. S. GARNSEY.
"Puerperal Eclampsia," - - - - - E. G. COX.

FIBROID DEGENERATION OF THE PLACENTA WITH MALFORMATION OF THE FŒTUS.

W. S. GARNSEY, M. D.,
GLOVERSVILLE.

I will not attempt to discuss this subject, but will merely state a case hoping that others more familiar with it and who have had more extended observation will discuss it thoroughly.

November 4th, 1898, I attended Mrs. Blank in confinement. She had previously had three premature births at different stages of development. She was 31 years of age, had been married six years. Her mother died at 45 of consumption, and a brother, the only other child, died of the same disease at 29. My patient says that up to 20 years of age she was as healthy as the average girl. During my acquaintance with her, a period of ten or twelve years, she has had a good constitution. She has suffered with catarrh of most of the mucous surfaces and a scorbutic condition of the gums.

She suffered for several days before labor really set in from severe uterine contractions, a condition which I have observed in other cases of mal-presentation. As soon as the os was sufficiently dilated I found

I had a foot presentation, and when the trunk was half delivered I observed a large hæmatoma over the lumbar region of the spine, palpation of which showed deficiency of the bony structures beneath, in short, a case of spina bifida. I then ceased all anxiety for the child and took my time caring only for the maternal safety. Nevertheless, a living child was born with a very large hydrocephalic head. I took two of my colleagues in to see it. The child lived 26 hours.

After carefully caring for the mother I examined the placenta and found two hard, smooth, light colored portions. They were conical in shape. The bases were an inch and a half or two inches in diameter. The apices, projecting from and beyond the rest of the placental surfaces, must have dipped into the uterine structure. The apex was the hardest portion of the tumor, and at the base it shaded off gradually into normal placental tissue. I cut off portions of these tumors and sent them to Dr. George F. Laidlaw, of New York, who reported that they were fibroid in structure.

The third day after confinement the patient had some convulsions and albumin was found in her urine, although none could be found the week before. Four weeks later she suffered from phlegmasia alba dolens in left thigh and leg. She has apparently made a complete recovery from both affections.

PUERPERAL ECLAMPSIA.

E. G. Cox, M. D.,
ALBANY.

In presenting to the Society a report of three cases of the eclampsia of pregnancy, my desire has been to show the marked contrast which different cases during the preparatory stage present; the variability of symptoms and the difficulty of correct prognosis in that symptom group which we call by the title of eclampsia. This variability in the unfolding of the disease undoubtedly depends upon the fact that this morbid state depends not upon one cause as the sole exciting agent, but that one factor or more in varying proportion are, at times, the producers of eclampsia.

To my mind three elements must be considered in the causation of eclampsia.

First, auto-intoxication, second, the interference with the circulation through the kidney, and third, the unstability of the patient's nervous system depending upon inherited tendencies or those acquired. In the acquirement of this nervous unstability the influence of the pregnancy as a factor must enter.

CASE I. 18 years of age. Became pregnant in June and was admitted to the House of Shelter the following January. Urine examined Jan-

uary 16th, showed specific gravity 1021, acid, no albumin, no sugar, slight swelling of the feet at night. January 29th, specific gravity 1017, acid, trace of albumin, no sugar. After last examination the specific gravity became lower, albumin always present, no sugar ever found. Feet and legs continually swelled. At time of delivery had convulsions and was delivered by manual dilatation of the cervix and forceps. Case recovered nicely.

CASE II. 17 years old, family history excellent. Patient entered the House of Shelter in June, having been pregnant since previous January. Examination of urine showed as follows: specific gravity, 1033, slightly acid, no albumin, trace of sugar and phosphates.

As pregnancy progressed specific gravity increased, amount of sugar increased, also phosphates. The day before birth of the child specific gravity 1051. Sugar in abundance, no albumin but large amount of prosphates. There had been no swelling of feet or limbs at any time. Convulsions came on and delivery was brought about at once. Recovery. Three weeks after confinement the urinary examination showed specific gravity 1018, acid, no albumin, no sugar and a few urates.

CASE III. 22 years old, admitted in November, having been pregnant since July. Examination of urine showed specific gravity 1019, acid urate, no albumin, no sugar. On every examination till the following April the specific gravity was never higher than 1022 or lower than 1018. No swelling of the feet or legs took place at any time. Patient was always in the best of health apparently, eating and sleeping normally; in fact she did not ever suffer from the petty ailments of most pregnant women. I was called to see her at 5:30 p. m. and found the labor just beginning and everything was apparently in the best condition, even the patient being in better spirits than most women are at those trying times. On returning at 8:20 p. m. found the os dilated to the size of a silver dollar, the bag of water forming nicely, but the position was L. O. A. I might add here that the patient's urine a few days previous to this showed a specific gravity of 1021, acid, no albumin, no sugar, phosphates and a few urates. While giving some directions to the nurse, without the least warning the patient was seized with a convulsion while sitting in a chair. A hypodermatic injection of morph. sulph. one-fourth gr. was given, the patient put to bed and an anæsthetic of chloroform administered. The cervix was fully dilated by hand and forceps applied. The urine that was drawn before the forceps were adjusted was saved. The following is the result of its examination; specific gravity 1010, acid, albumin, half of the bulk in the test tube solidified in boiling.

Patient never rallied and died next afternoon at 4 p. m. All urine drawn after delivery showed almost a solid condition of albumin, the specific gravity running from 1010 to 1004. Patient never regained consciousness, was in a comatose condition till death. In the three cases quoted at once is perceived the vast difference in all symptoms preceding the convulsions. As to the cause of eclampsia we may place first: disease of the kidney caused by auto-intoxication which may come from intestinal putrefaction aided by the notorious fre-

quency of constipation and by auto-intoxication from tissue waste. All of which are poisons and must be excreted by the kidney and hence become irritant to the kidney.

Secondly, pressure due either to the abnormal position of the head as in Case III. on the ureters or to the increased bulk of space taken up by an enlarged uterus pressing upon the various organs in the pelvis.

Third, nervous degeneracy; as in these three cases reported, the mental influence as a depressive agency must be considered as causing nervous unstability, as all these occurred among inmates of the House of Shelter and the issue in each case was illegitimate.

Burchard, in his investigations, brought out the fact of the poisonous conditions existing from pressure exerted either upon the intestines or kidney and that if this condition exists poisons were formed in the system which are excreted by the kidney. Prof. Stewart, in his paper on eclampsia, simply reiterates Burchard's theory by calling attention to the fact that the urine of a pregnant woman is always poisonous. When this poison is dammed back in the system on account of the non-action of the excretory organs we must expect bad results. To my mind there is only one conclusion to be drawn from his statement and that is, if the condition of the urine shows toxic results it simply means auto-intoxication is going on and is due primarily to the causes mentioned before. To discover this toxicity he advises experiments on rabbits and try and discover the extent of the toxic condition of the patient.

If the patient has suspicious symptoms experiment with rabbits, inject one with the urine and note its effect. If it is rapid in its action then be prepared to aid your patient in a wise way. Keep record of all the excrementitious matter; if the urine secreted is below the normal amount aid her, if the bowels are sluggish aid them. If with the means at our hands we can not succeed, bring on labor before you have the patient at death's door and can only thank God and not yourself that the patient "pulled through."

In conclusion I have only to add a few hints that have been told before but never too often. Examine the urine of every case of pregnancy in regard to the presence of albumin, sugar, urates, etc. Once a month at least for four months and then every two weeks till confinement. If a case demand it do it even oftener. Prodromal symptoms are very clear. Pain in the head, in the epigastrium or under the clavicle; failure of vision, great restlessness, stupor, eyelids twitching. All these are signs by which we may benefit ourselves and our patients by observing them. All these symptoms, or any of them, taken in connection with the condition of the amount excreted by the bowel and kidney should forewarn us of impending trouble and prepare ourselves accordingly.

REPORT

OF THE

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

"A Case of Superficial Degeneration of the Retina," - C. H. HELFRICH.
"Some of the More Remote Effects of Eyestrain," - G. W. McDOWELL.

A CASE OF SUPERFICIAL DEGENERATION OF THE RETINA.

CHAS. H. HELFRICH, M. D.,
NEW YORK.

My object in presenting this case is not primarily to call your attention to a new diagnosis, as it is not my own, but to cite an interesting and uncommon case which, despite its unfavorable course at first, terminated very happily under proper care. The prognosis and advice of my consultant in the case may some time perhaps be valuable to you.

E. M. K., age 26, of fair complexion, by occupation a clerk, called on me April 6th on account of a black spot before the right eye which had appeared for the first time on the previous day.

Four months before he found it necessary to consult me for the relief of headaches and asthenopic symptoms. At this time I made a careful examination of his eyes with the following results:

O. D. 15/20; + 0.50 Dc axis 90° = 15/15.
O. S. 15/20; + 0.75 Dc axis 90° = 15/15.
Esophoria 1° in the distance. Exophoria in accommodation 1°.
Fundus absolutely normal.

Glasses were prescribed which relieved his symptoms and he experienced no trouble for four months, when the scotoma referred to appeared.

The refraction of both eyes has remained unchanged and the vision in the affected eye is normal as well as that of its fellow. On taking his field, the scotoma was found to be both central and positive.

The ophthalmoscope revealed a small, irregularly round black patch in the macular region, compact but thin, giving the impression that only the superficial layer of the retina was involved. The optic nerve and the balance of the retina were absolutely normal in appearance.

He is an enthusiastic amateur photographer and for some time had been occupying his leisure hours at this work. Something which he felt had tried his eyes severely was the construction of an apparatus for the enlargement of photographs which not only necessitated considerable mechanical skill but close application of his eyes. He frequently worked far into the night and had done so the night before the scotoma appeared. There is no history of syphilis either hereditary or acquired. Dr. Malcolm Leal examined a specimen of his urine but found nothing abnormal. An examination of the heart by the same physician proved negative.

A black patch in the macular region with no other ophthalmoscopic signs suggested a central choroiditis or an areolar choroiditis, but as it did not resemble any other case of the kind I had ever seen before I was not at all clear as to the diagnosis. He was put upon iodide of potash and sulphate of strychnine.

While his vision was normal at first it rapidly diminished. At the end of a week it was only 15/40 and one week later 15/70. The appearance of the spot remained unchanged and the nerve throughout appeared perfectly normal.

I now suggested his consulting Dr. Herman Knapp, to which he assented. Dr. Knapp wrote me a note diagnosing the case as superficial degeneration of the retina due to overuse of the eyes. Medicine, he stated, was unnecessary, and the vision would speedily return if the eyes were given absolute rest. Such a favorable prognosis in the face of the rapid loss of vision was pleasant news not only to the patient but to myself.

It was impossible for him to give up his work at the bank, but he promised not to use his eyes outside. The medicine was continued. The restoration of vision was as rapid as its loss and within several weeks had returned to normal, though the patch in the macular region remain unchanged and the scotoma was present when he looked for it.

At my request the patient presented himself on January 2nd for an examination. After the lapse of six months a small reddish-yellow spot was found in the macular region, somewhat larger than the original patch, in the center of which was a faint trace of pigment. The vision was normal and the scotoma not demonstrable with the perimeter.

On January 21st, since writing the above, the patient returned complaining of a Y shaped opacity made up of thin black lines. An examination of the fundus revealed a small crescentic-shaped, reddish-yellow patch situated above the original patch. The media were perfectly clear and the vision normal. The perimeter did not show a scotoma.

No further change has occurred up to date, February 6th.

SOME OF THE MORE REMOTE EFFECTS OF EYE-STRAIN.

GEORGE W. MCDOWELL, A. M., M. D.,
NEW YORK.

During the past few years the medical profession have accepted to a great degree the contention of the oculist that eye-strain was responsible for many headaches, which were formerly attributed to disturbances of the digestive organs. Even the laity have come to a recognition of this relationship, and frequently consult an oculist in the first instance for relief from the so-called bilious headaches, which have been often found solely dependent upon a faulty refraction, with no hepatic derangement except secondarily.

The close connection between the eye and the brain is so manifest that it does not seem so very surprising that an affection of the former should produce a disturbance of the latter. If we accept as a fact that headaches may be the result of eye-strain, may we not carry the theory a little further and say that any part of the organism may be similarly affected from the same cause? Who can say in reference to any abnormal nerve impulse, "thus far shalt thou go but no farther"? A pebble tossed into a quiet pool produces ever-widening circles whose influence can never be measured. May we not have a similar disturbance of nervous equilibrium, the effects of which may be manifested at points far removed from the original centre of irritation?

It is an accepted fact in mechanics that the motive power required for any machine is proportionate to the amount of friction developed. A machine with ball bearings and a perfect adjustment of all its parts requires much less energy to perform any given work than does one in which the parts are ill-adapted to each other and produce the maximum amount of friction at every point of contact. The human body may be considered a machine-shop, every organ whether of vegetative life or of special sense having its particular work to perform, and all receiving their motive power from the same central station. If in such a shop some one machine from faulty construction should develop undue friction, it will demand greater motive force to move it, and if the center of power be already taxed to its maximum, every machine in the shop will feel the drag and be perceptibly slowed down. Or again, we may state the proposition in this fashion: given a definite amount of nerve force to be divided among all of the organs of the body; if any one organ demands more than its proportion to perform its functions properly, because of some inherent structural or functional defect which requires increased innervation to overcome, then we may conclude that some other organ will suffer from diminished innervation and consequent impairment of its functional activity. Nature is, however, a generous provider, so that, in perhaps a majority

of the cases of refractive and muscular defects, the excessive use of nerve force by one organ has no perceptible influence upon the rest of the body. This is fortunate, for otherwise the majority of us would suffer from the effects of eye-strain, so wide-spread are refractive and muscular errors. But the over-supply of nerve force is often impaired by disease, and in many other cases was never superabundant. It is in such cases as these that eye-strain produces many reflex symptoms, and some of them in organs far removed from the eyes. It was Dr. Prentice, of Chicago, who applied to this form of nerve waste the term brain leak.

It will not be necessary to enter into any lengthy description of the refractive errors likely to produce eye-strain, as all are more or less familiar with this subject. Hyperopia, hyperopic astigmia, myopic astigmia, and mixed astigmia are the forms most likely to give rise to symptoms, if they are of small enough amount. Those cases only give trouble in which by an effort, perhaps unconsciously made, the patient can maintain clear vision. As this can be done only in case of error of a low degree, it will be seen that these are the ones that most of all need correction. Strange as it may seem there are still oculists of high reputation who disregard errors of half a diopter or less in their prescriptions for glasses. The fact that these small amounts are considered important by many is shown by the introduction within a few years of a lens of one-eighth of a diopter.

In addition to refractive errors as a cause of eye-strain, a lack of balance in the extrinsic muscles of the eye will also give rise to similar results. If an eye has a tendency to turn in or out, up or down, a greater expenditure of nerve force is required to maintain parallelism of the visual lines, and so avoid diplopia, than is necessary in a normal eye. When the turning of the eye amounts to an actual squint, the strain on the nervous system is largely removed; for since it is impossible to fuse the images seen by the two eyes when the deviation is a large one the attempt is not made, the image seen by the squinting eye being simply suppressed and causing very little annoyance. The same rule holds good for muscle troubles that applies to refractive errors, viz.: that the small faults that can be overcome by an effort are the ones that cause the greatest drain on the nervous system, for the reason already stated.

Indigestion is not characterized solely by heaviness and distress in the epigastric region, but often shows itself in a dull frontal headache and pronounced irritability. In like manner defective eyes may produce symptoms at points far removed from the organ at fault.

The writer is not willing to admit that all abnormal innervation arises from faulty refraction or unbalanced ocular muscles. However pleasing to the oculist such a conception might be, it is certainly not at all in harmony with observed facts. For while cross-eyed children have a known tendency to nocturnal enuresis, intestinal worms have often caused temporary strabismus. Cases are sometimes seen in which correction of refractive errors does not give relief to eyes that pain and heads that ache, until some diseased condition of the

uterus or ovaries has received proper treatment. When it becomes a question of removing an ovary or an eye, ovariotomy should undoubtedly take precedence. If it be a question of an ovariotomy or an operation on the eye muscles, then let the gynæcologist give way to the oculist. A most striking illustration of the inter-dependence of these organs is shown in a case reported by Dr. C. H. Vilas in the Homœopathic Eye, Ear and Throat Journal for April, 1898. The patient, a woman forty-seven years of age, has suffered from an inflammation of the left eye for more than a year. There was intense pain, swelling, redness and photophobia, with no discoverable organic change in the eyeball. Treatment by a number of oculists with a stay of several months in an ophthalmic hospital had afforded no relief. Enucleation for the relief of pain had been advised and the date set for the operation. The patient had noticed a growth in the region of the left ovary for about a year, and when she was brought to Dr. Vilas for a final opinion concerning her eye, his attention was directed to this tumor. Believing that as it had developed coincidently with the ocular trouble it might stand in a causal relation to it, he advised the removal of the growth. The result proved the wisdom of the advice, for the ovariotomy was followed by an immediate disappearance of all eye symptoms. The following cases will serve to illustrate the remote effects of eye-strain.

CASE I. B. G., æt. 25. Applied for treatment December 12th, 1889. Has suffered from headaches for five or six years, becoming more severe during the past year. Headaches sometimes begin with a blurring of vision, followed by pain over the eyes, especially the left. At other times the attack begins with a feeling of numbness in the right hand and arm, followed by headache with nausea. An examination under atropine showed mixed astigmia of one-quarter of a diopter in one meridian and half a diopter in the other. These glasses were worn with entire relief of the headaches as well as the numbness in the hand and arm. She was seen two years later with no return of the symptoms.

CASE II. Mrs. W. M., æt. 48. Was first seen October 15th, 1896, when she presented the following history: Has pain in the right eye and the back of the neck at intervals of a day or two, if using her eyes to any extent. Complains of a numbness of the inside of the right foot, the great toe particularly having had no sensation in it for several years. The especial reason for her visit was on account of a trembling of the head and arms which had been diagnosed as paralysis agitans. She had been under treatment for this condition for some time. One physician had ordered eighteen fly blisters applied to the spine. Having used thirteen of them without benefit she discontinued the treatment. Another had recommended an iron frame to steady her head. An examination of the eyes showed the following conditions:

O. D. 20/200; + 1.50 Dc axis 105° |— —3.25 Dc axis 30°=20/20.

O. S. 20/20. No manifest hyperopia.

Examination of the muscles showed exophoria 12 degrees for distance, and right hyperphoria 5½ degrees.

That is, the eyes instead of being parallel without effort when looking at an object twenty feet distant had a divergence of 12 degrees, and a difference of level of 5½ degrees. This demanded a constant expenditure of nerve force to overcome the divergence and prevent diplopia. The difference of level was corrected by tilting the head to one side. A tenotomy of the right external rectus reduced the divergence to 1½ degrees immediately after the operation. The next day the patient volunteered the remark that she had the evening before eaten soup from a spoon without spilling it for the first time in several years. After the first operation the difference in level had entirely disappeared. One month later the remaining exophoria, which at this time amounted to 6½ degrees from the cicatricial contraction, was intentionally overcorrected by a tenotomy of the left external rectus. Three weeks later this patient's eyes were parallel both in the vertical and horizontal planes. The refraction was now tested under a mydriatic and glasses prescribed for distant and near vision.

The results of the treatment were as follows: Relief of occipital pains. Disappearance of the trembling of the head and arms so that she can now sew without pricking her finger with the needle. The numbness of the inner side of the right foot ceased immediately after the operation. She now uses her eyes with comfort.

CASE III. Miss M. I., æt. 18. Was first seen February 7th, 1894, when she complained of frequent frontal and occipital headaches. Her eyelids are constantly inflamed. Had been under treatment a year before for acute nephritis. At present has frequent desire to urinate due to an irritable bladder. Right ovary is sensitive to pressure and painful. Family physician had advised its removal. Examination of the eyes showed:

O. D. 20/30; + 0.67 Dc axis 120 degrees=20/15.

O. D. 20/15; + 0.12 Dc axis 120 degrees=20/15.

These glasses were given for constant use and have proven of great benefit. The irritable bladder was relieved, the ovarian pain ceased and her eyes lost their redness. When, as frequently happens, she breaks her glasses and is without them for twenty-four hours, all of the old troubles return, the eyes becoming red, the bladder irritable, and the ovary painful.

CASE IV. Miss H. N., æt. 30, applied for treatment April 16th, 1894. Has had epileptic attacks for fifteen years, following a fright caused by a runaway horse. Had been taking bromides for two years with no return of the attacks until a short time previous to her first visit, after stopping the drug for some time. Her attacks usually come on at night soon after falling asleep. Is very nervous. Has a capricious appetite. Is subject to frequent headaches in the forehead, vertex and occiput. Feels less nervous when she has a headache than at other times. An examination of the eyes showed a manifest hyperopia corrected by a +0.75 Ds. lens. A divergence of the visual lines was found amounting to 1 degree for distance and 4 degrees in accommodation. Spherical glasses were prescribed for constant use, with

prisms of one degree base inward in addition for near work. Since wearing these glasses she has had no further attacks, and the desire to throw herself down to the street when looking from a high window, which was always present before, has entirely passed away. The patient has gained thirty pounds in weight, and has no occasion to resort to bromides.

The writer has seen a number of instances of indigestion of long standing which disappeared after refractive errors had been corrected, without change in the patient's habits or any treatment directed to the stomach. Stevens, Ranney and other reputable observers have reported cases of chorea, epilepsy, spinal irritation, sleeplessness, nervous prostration and insanity as having been cured by a correction of a coincident eye fault.

While some of the alleged results of eye-strain may seem somewhat extravagant, and the cures little short of miracles, still it must be remembered that defective eyes are under a more constant strain than any other organ of the body, as their only chance for rest is during sleep. The heart has a period of rest after each impulse that amounts to a considerable proportion of the whole time from one beat to another. We are all well aware of the frequency with which this organ becomes exhausted when called upon to perform any excessive work for a long period, as in pneumonia when it is working against increased pressure. Even a normal heart may fail under the strain, and one whose functions are hampered by disease of the valves or of the muscular fibre is almost certain to break down. Is it any wonder then that an organ so delicately constituted as that of vision, made up of two separated parts which must work in absolute unison in order to form a sharply defined image of the objects seen, which is so freely supplied with nerves of cerebral origin, and which is in such direct connection with the brain itself by continuity of tissue,—is it any wonder that such an organ, when working against the drag of refractive error or lack of muscular balance should so disturb the equilibrium of the nervous system as to give rise to functional disorders in remote parts of the organism?

PROCEEDINGS

OF THE

Thirty-Third Semi-Annual Meeting, held in Binghamton, Tuesday and Wednesday, September 19th and 20th, 1899.*

President JAY W. SHELDON called the Society to order in the Hotel Bennett at 10:21 a. m. and prayer was offered by Rev. Edward Taylor, D. D.

Hon. JEROME DEWITT, Mayor of Binghamton, was then introduced and said:

Mr. President: I am very happy to have the opportunity of giving the disciples of homœopathy a very cordial welcome to the city. We deem it an honor that you have selected Binghamton as the place of meeting for the thirty-third semi-annual meeting of your Society. The time seems to be opportune; it is but a few short weeks since we had a convention here, the State Convention of Undertakers, and now behold, come the Doctors! This may seem out of the usual and ordinary course of procedure of these professions, but some intelligent writer has observed that "after death the doctors!" And I believe that the undertakers, with their usual shrewdness and astuteness, anticipated your convention and reached the conclusion that after the doctors of your school of practice should come to town, their occupation would be gone. (Laughter.) I had been led to believe from recent developments that there would be no more conventions of physicians and that the profession would be relegated to the rear in the march of human progress, or be altogether outlawed in this country. It had remained for a member of my own calling, a judge somewhere down in the Nutmeg State, to discover and proclaim the right of man to die without the hindrance of physicians (laughter) and that the physicians by prescription and treatment have no right to interfere with the ordinary course of nature or to thwart it in its course. After this and after the physicians should have been fully advised, I had believed that they would be ashamed of themselves and that they would make proper acknowledgments and what reparation they could to the people that they had injured and wronged, and that they would discontinue the practice of medicine, which was reprobated by such high judicial authority (laughter). Indeed, I

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*Stenographer, Francis E. Wessels, Lippincott Building, Philadelphia, Pa.

believed that they would cease the practice of medicine altogether and abandon the doctrine of similia similibus curentur and embrace the more simple doctrine of what is to-day will be and allow nature to take its course and the patient to take the consequences (laughter). However cogent and feasible the doctrine of the learned judge from Connecticut may seem, I am satisfied that people are not prepared to abandon it or consent that the doctors should abandon them. You are the first to receive us on coming into the world, you keep watch and ward over us during our life and it is expected and hoped that you will continue our earthly assistance as long as possible. No, the physician is perhaps the most important man. He is a member of one of the most honored and learned professions and has endeared himself to the hearts of the people. He is the first to receive us and the last to depart from us and he is our constant and particular company from the cradle to the grave, and the people, I believe, will not consent to dispense with his services. The physicians watch over our bodily and physical well-being as the doctors of divinity over our moral and spiritual.

Ladies and gentlemen, I am very glad to have met you this morning and to have made your acquaintance, and I shall be happy to do anything I can to render your sojourn in this city a pleasant and agreeable one. We have some institutions here which may be of interest to you in the line of your profession, some which make and contribute to your comfort, your happiness, your amusement. We have a city hospital here, maintained by the municipality, and open to both schools of medicine. There are there many patients receiving much benefit—cures for disease and injury—and it is also, I believe, a place for training of nurses. We also have a state hospital for the insane, which is one of the largest and best equipped and most complete within the Commonwealth. There are detained there, I believe, all the time from thirteen to fifteen hundred patients of every variety of mental disorder. I believe that you will find it of interest to visit both of these institutions and that your time in doing so will be well spent. We also have casinos, public parks, street railroads and opera houses galore, and I presume that you will find your way to some of them. Our municipal buildings are new and modern in their course of construction, handsome and complete, and I certainly hope that you will take an opportunity to visit them. I reiterate and emphasize the cordiality of my welcome and I hope that your visit here and your convention will be as pleasant and profitable as it would have been possible for you to anticipate.

E. E. SNYDER: Mr. President and Members—As President of the Broome County Society it devolves upon me to extend to you a word of welcome which seems hardly necessary after the remarks by our Mayor that we have listened to; but I would say, in behalf of our local society, we are certainly very glad to see you here and believe that it will be a benefit to us. How else could it be with such a distinguished body of persons medical? We believe that the papers and discussions which will follow in the ensuing meeting will be of personal benefit

to us and contribute to the up-building of the medical profession in our midst, and we hope that you will take every opportunity to enjoy your sojourn among us. We have reason to thank you for your presence.

President SHELDON: The program calls for opening remarks by the President as the next order of business. A precedent has been established making it the duty of the presiding officer to offer such suggestions as he may deem advisable for the Society to consider or act upon during the session, and to call attention to such matters as may be of interest to the profession.

In assuming the duties and responsibilities of the Chair, I shall rely upon your assistance in dispatching the work of the meeting—also beg your indulgence for any errors which I may make. Permit me to express great pleasure in this relation and profound appreciation of the honor conferred by the Society in making it possible for me to preside over the deliberations of this distinguished body of physicians. In this thirty-third semi-annual gathering of the Society we have reasons for congratulations upon the general success of our meetings. It appears to be the universal verdict that the last semi-annual was one of the best in the history of the organization, both from a scientific standpoint and in the matter of attendance.

Allow me first and chiefly to call attention to the Legislative Committee. It appears that many, perhaps most, of our physicians do not realize the importance of this committee and its achievements. The indispensable value, not only to the Society but to the whole profession of an active, aggressive, level-headed legislative committee, cannot be over-estimated. Dealing as it does with questions affecting our professional rights, liberties and even existence, there is no part of this body politic which should more fully command our respect, enlist our interest or to which we should more readily respond. Our committee has a noble record of past accomplishments; it is necessary only to mention the separate examining boards law which stands as a monument to its efficiency. More recently and continually the good work of this committee has gone and is going on. In the fertile legislative fields at Albany, in touch with the warring, struggling elements and interests of this great State, it finds no "off year" when homœopathic affairs are not in question. In illustration permit me to call your attention to the following facts which appear in the September number of the *North American Journal of Homœopathy:* During the past session of the Legislature, some 200 bills affecting medical interests or public health were introduced into the Senate and Assembly collectively. Of these, only forty-one became laws. Many dangerous bills were defeated; I will mention one, namely, a bill to allow volunteer surgeons in the army and navy, whether they had or had not seen active service, to practice without examination. This bill passed both houses and went to the Governor but was there killed. The fact that so small a proportion of the measures above referred to became laws is due to the vigilance and joint work of our Committee

and that of the old school. During the session every bill opposed by our committee was defeated and every one which they approved was passed, with the exception of that providing for the establishment in the Adirondacks of a State Hospital for the treatment of incipient tuberculosis. This was an old school bill, modified so as to be acceptable to us, then endorsed and furthered by our Committee, but perishing for lack of appropriation. While it is not the policy of the Legislative Committee to burden the members of the Society with its work, it not infrequently happens that measures of most vital importance hang in the balance and require the demonstration of general interest and influence for or against them, as the case may be, throughout the State. Occasionally it requires every bit of pressure which can be brought to bear to defeat a pernicious bill or to save a good one. Had our Legislative Committees stopped for times or seasons, distance or expense, there would have been no Gowanda (Collins) State Homœopathic Hospital. In weighty affairs it is becoming each year more necessary to organize in legislative matters; as this practice grows more general we must expect to meet organized opponents, which can be successfully done only with organization ourselves. Occasionally there will develop at Albany a situation so critical or an undertaking so great that your Committee, work as it will, is physically unable to compass it, or one requiring an overwhelming display of sentiment for or against. At such times you may receive urgent requests to send certain telegrams, write some letters, or to see designated people in the interest of the cause. Be assured that such requests will not be triflingly made. Each should be treated as an important business matter which you cannot afford to disregard.

Another point on which I wish to touch is that of membership. When you take into consideration the fact that less than one-half of the homœopathic practitioners of this State are members of this organization, you will readily see why. It will be admitted that, but for this organization, we should have no protection, no representation, no professional standing; in fact, would be like sheep without a shepherd. I am constrained to believe that the large majority of our physicians do not appreciate the protection they have received from the State Society, otherwise they would become identified with it. After this Society has been in existence forty-nine years, I feel compelled to make an earnest appeal for new members.

I ask every homœopathic physician in the State to join this Society, thus discharging an obligation which he owes to himself and, as well, to those who have protected his rights, maintained the honor and dignity of the name "homœopath" and made it possible for him to practice his chosen profession in peace.

Finally, I desire to call your attention to the Hahnemann monument fund. Omitting an array of statistics and data, which any one so desiring may obtain from Dr. Henry M. Smith, 288 St. Nicholas Avenue, New York City, I would state that the contract price of the monument is $48,800 on which the sum of $27,800 is still due. You will be astonished, as was I, to learn that, of 10,000 homœopathic physicians in

this country, less than 10% have contributed anything to this fund. I believe that the physicians of New York will feel the above to be so unsatisfactory, and will so heartily wish to relieve the grand old Empire State of any share in such a showing, that they will hasten to do their part—and more than their part—toward effacing it. I trust that at this meeting means may be devised to raise before January 1st a handsome sum. Permit me also to suggest that steps should be taken to effectively reach the bulk of the profession who do not attend society meetings or attend to letters. Let me assure you that it is with reluctance that I speak of this matter to those who have doubtless liberally subscribed, and who have listened to repeated appeals both in this and in other bodies. If, however, it may result in touching the hearts—and pockets—of some of those nine-tenths, I am sure that you will pardon me. And now as you go from this place to your respective fields of practice, carry these thoughts with you, and make an effort to enlist the members of your medical society and friends of homœopathy to do their share in honor of Hahnemann and homœopathy.

The President then appointed as the

COMMITTEE ON ATTENDANCE,

L. A. MARTIN, F. D. LEWIS and C. A. GWYNN, who, at the close of the meeting, reported fifty-one members and nineteen visitors in attendance.

Allegany County—B. Williamson.

Broome County—D. P. Bailey, Elizabeth Corwin, G. H. Jenkins, L. A. Martin, D. H. McGraw, W. H. Proctor, J. F. Roe, T. S. Turner, C. A. Ward—9.

Cayuga County—C. F. Barnes.

Chemung County—E. C. Eddy.

Chenango County—R. E. Miller.

Erie County—D. H. Arthur, J. G. Chadwick, J. T. Cook, Fred D. Lewis, F. Park Lewis, C. A. Potter, DeWitt G. Wilcox—7.

Genesee County—J. W. LeSeur.

Kings County—W. M. Butler, John L. Moffat, E. H. Muncie, Libbie H. Muncie, H. D. Schenck—5.

Monroe County—N. M. Collins, J. M. Lee, S. R. Snow, Julia F. Haywood—4.

New York County—Louise Z. Buchholz, Bukk G. Carleton, J. T. O'Connor, E. H. Porter, G. W. Roberts, G. G. Shelton—6.

Onondaga County—J. W. Candee, W. L. Hartman, G. W. Hoyt, W. H. Leonard, J. W. Sheldon—5.

Orleans County—Emily F. Swett.

Steuben County—E. W. Bryan, M. S. Purdy, A. H. Rodgers—3.

Tioga County—J. T. Greenleaf, H. E. Merriam, D. G. Van Ostrand—3.

Tompkins County—M. Besemer.

Wyoming County—W. B. Gifford.

Susquehanna, Pa.—Silas S. Simmons.

The minutes were read from advance sheets and adopted.

THE REPORT OF THE BOARD OF CENSORS

recommended the following 8 who were thereupon elected Permanent Members:

	ENDORSERS.
JOHN G. CHADWICK, Buffalo, II*, '96,	D. G. Wilcox, W. B. Gifford.
J. MUMFORD KEESE, Syracuse, IV, '98,	G. W. Hoyt, W. L. Hartman.
E. OLIN KINNE, Syracuse, III, '78,	W. L. Hartman, A. B. Kinne.
WM. H. LEONARD, Tully, I, '91,	W. L. Hartman, E. W. Bryan.
D. H. MCGRAW, Binghamton, I, '88,	L. A. Martin, E. E. Snyder
PETER J. MACPHERSON, Millport, II, '90,	E. W. Bryan, E. H. Porter.
CLARENCE A. POTTER, Gowanda, I, '97,	D. H. Arthur, G. F. Adams.
D. G. VAN OSTRAND, Candor, I, '95,	E. E. Snyder, J. F. Roe.

The Secretary read a letter from Dr. Dearborn, Secretary of the New York Homœopathic Medical College and Hospital, in response to the Society's resolution of February 15th (see p. 20) stating that they have a course of lectures on military surgery and lectures on military hygiene in the department of hygiene in the college course, and that they would be continued during the next college session.

THE REPORT OF THE NECROLOGIST,

W. S. Garnsey, consisted of obituaries of W. S. TALCOTT, SUE A. WHITE and T. C. WHITE. (See Appendix.)

THE REPORT OF THE EXECUTIVE BOARD

was read by the Secretary.

This Board held no meetings but acted by correspondence. We voted not to publish one of the papers presented last February because it had been previously presented to another society. The Board deemed it due to the dignity of this Society to take this action and establish this precedent.

In response to the initiative of a member who is not an officer the Board decided to have a stenographer for this meeting, as an experiment.

The time and place of this meeting having been left to the Board, with power, you are here to-day.

JOHN L. MOFFAT, Clerk.

L. A. MARTIN: Through the courtesy of Dr. Charles G. Wagner, Superintendent, this Society is invited to visit the Binghamton State Hospital.

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*I—New York Homœopathic Medical College and Hospital.
II—Hahneamann Medical College, Philadelphia.
III—University of Michigan.
IV—Hering Medical College.

BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

E. W. BRYAN, Chairman, presented three papers:

"The Conditional Survival of Homœopathy," by MARK S. PURDY.

"A Case from Practice," by E. W. BRYAN.

"A Case of Leucæmia," by C. R. SUMNER.

On motion, the privilege of the floor was extended to visitors.

BUREAU OF GYNÆCOLOGY.

W. H. PROCTOR, Chairman, had four papers, one of which (upon "Extra-Uterine Pregnancy") was read in the absence of the writer by especial vote; it is not published because it had been read before the Medico-Chirurgical Society in Syracuse last fall.

"Vaginal Hysterectomy," by LIBBIE HAMILTON MUNCIE.

"Objection to Vaginal Section for Pelvic Disease," by DEWITT G. WILCOX.

"The Homœopathic Prescription vs. Mechanical Intervention," by GEORGE E. GORHAM.

BUREAU OF PÆDIATRICS.

JOHN L. MOFFAT, in charge, consisted of three papers:

"A Circumcision Shield," by JOHN L. MOFFAT.

"Tubercular Meningitis," by F. W. HAMLIN.

"The Temporary Teeth," by CHARLES G. PEASE.

FIRST DAY.—AFTERNOON SESSION.

The Society was called to order by the President at 2:30 p. m.

BUREAU OF SURGERY.

N. M. COLLINS, Chairman, reported three papers, and read a letter of regret from Dr. Walton.

"Uterine Fibroids," by W. L. HARTMAN.

"The Scope of Posterior Colpotomy," by SHIRLEY R. SNOW.

"Gall Stones," by NEWTON M. COLLINS.

At the close of this Bureau the Society was thirty minutes ahead of schedule and papers which had been presented by title were read.

BUREAU OF NEUROLOGY.

D. H. ARTHUR, Chairman, presented five papers:

"Remedies Reliable in Mental and Nervous Disease," by WM. MORRIS BUTLER.

"Suggestions for Change in the Lunacy Laws," by JOHN T. GREENLEAF.

"The Opium Habit," by AMOS J. GIVENS.

*"False Beliefs," by JAMES PURCELL, of Easton, Penn.

Chorea," by A. P. POWELSON.

Dr. Butler prefaced his paper with a notice of our jubilee meeting next year.

FIRST DAY.—EVENING SESSION.

The meeting was called to order by President SHELDON at 8:18 p. m.

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

*"Shall We Cut the Ocular Muscles?" by E. H. LINNELL, of Norwich, Conn.

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

FRED D. LEWIS, in charge, announced two papers:

"Nasal Stenosis and Its Relation to the Voice," by HORACE. B. WARE, of Scranton, Penn.

"Aphonia," by FRED D. LEWIS.

At the close of this Bureau the Society was again ahead of time and listened to papers which had been presented by title.

At ten o'clock the Society adjourned and was pleasantly entertained—in the same room—with recitations, etc., by a Mr. Weeks and rag time songs by three of the colored table servants in the hotel. Cigars and refreshments contributed to the success of the evening.

SECOND DAY.—MORNING SESSION.

The Society was called to order at 10:07 a. m. by President SHELDON.

BUREAU OF PUBLIC HEALTH.

J. W. LESEUR, Chairman, made an address on the subject reviewing the progress of the year. He then announced three papers:

"Sanitary Sewerage in the Smaller Cities and Towns of this State," by F. P. WARNER.

"Heredity, Environment and Food in Their Relation to Consumption," by EMILY F. SWETT.

"Sanitarium Care of Consumptives," by H. P. DEADY.

*Read by title.

BUREAU OF OBSTETRICS.

J. W. CANDEE, in charge, presented three papers:

"A Clinical Experience in Puerperal Eclampsia," by J. WILLIS CANDEE.

"Albuminuria of Pregnancy," by JULIA F. HAYWOOD.

"The Use of the Fillet in Breech Cases," by GEORGE R. STEARNS.

BUREAU OF MATERIA MEDICA.

GORDON W. HOYT, Chairman, submitted two papers:

"The Study of Materia Medica the Safeguard of Homœopathy," by GEORGE G. SHELTON.

"Verbascum Thapsus," by W. A. DEWEY, Ann Arbor, Mich.

MISCELLANEOUS BUSINESS.

The Secretary reported for the Treasurer that four of those elected to membership last February have dropped by failing to qualify, viz.:

E. F. M. AYRES, of Saratoga.
FANNY DONOVAN-CONKLIN, of New Brighton, New York.
STUART J. FAIRBANK, of Deansboro.
JOHN W. HODGE, of Niagara Falls.

Each one of the eight elected at this meeting has qualified already.

JOHN L. MOFFAT gave notice of an amendment to By-Law V, § 2 so that it shall read: "No paper nor report shall be received or published that has previously been either published or presented to another society, or that is in an unfinished condition."

On motion of E. H. PORTER, it was voted that:

It is the sense of this Society that the establishment of a State sanitarium for consumptives in the Adirondacks should be promoted for the public welfare, and this Society cordially endorses the project.

On motion, the thanks of the Society were tendered the doctors of Binghamton for their courtesy, and especially to Lynn A. Martin, for making our visit so pleasant.

L. A. MARTIN: I move the thanks of this Society to Dr. Waggener for his invitation to visit the State Hospital. Carried.

President SHELDON: I desire to thank the chairmen for their successful efforts to make our program of such a high order, and wish to express to every member present my appreciation of his or her kind attention and loyal support during this meeting. We have completed our program on time, every paper (with but two exceptions) has been read at length, every member who desired to speak has had opportunity, has had time to finish his remarks, and none have transgressed the time limit. I am under obligations to the local physicians for their cordial hospitality and interest in the meeting.

On motion adjourned. JOHN L. MOFFAT, Secretary.

REPORT

OF THE

BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

"The Conditional Survival of Homœopathy." - - MARK S. PURDY.
"A Case from Practice," - - - - - E. W. BRYAN.
"A Case of Leucæmia," - - - - CHARLES R. SUMNER.

THE CONDITIONAL SURVIVAL OF HOMŒOPATHY.

MARK S. PURDY, B. S., M. D.
CORNING.

The early pioneers of homœopathy were subjected to ridicule, opposition and vituperation from the members of the dominant school to a degree that is difficult for us to appreciate. But this opposition resulted to the advantage of homœopathy. The persecuted homœopaths became more positive in their belief, more confident in the truth of their cause and more aggressive in its promulgation. In those days the gulf which separated the two schools was wider and the difference in treatment was vastly greater than obtains to-day. On the one side they had calomel, the lancet, blistering and purging as the fashionable modes of medical treatment; with the other school there were remedies easily taken, prompt and pleasant in their effects. It is no wonder many shrank from the nauseous drugs and chose the sugar pellets!

What are the conditions that prevail to-day? The so-called regular school has condensed its dose into a tablet triturate and sugar or chocolate coated it until the people scarcely know the difference in the remedies of the two schools. We too read their text books; our students elbow theirs in the surgical clinics and the post-graduate schools. Our surgeons, our oculists and our gynæcologists are scarcely distinguishable from theirs in much of their treatment. What then is taking place? While we have become more liberal and broader in our views, we are threatened with either extinction or loss of identity. We are liable to become the victims of "benevolent assimilation."

It is obvious that the survival and continuance of the homœopathic school is dependent upon the character and the enthusiasm of the

young practitioner entering its ranks. But what has the young man to-day to consider as he enters the homœopathic school of practice? On the one side he observes that the so-called regular practice outnumbers ten to one the other system. The allopath has sweetened and modified his dose; he has control of the largest hospitals and medical schools. His practice has become simplified so that when he wishes to prescribe all he has to do is to open his case and choose a tablet triturate which some pharmaceutical house supplies him all ready compounded and labeled. He needs only to read the labels and there he has before him: heart tablet, neuralgia pill, diarrhœa tablet, etc., as the case may be. The plan is simplicity itself. You touch the button and the pharmaceutical chemist does the rest.

Let us look, on the other hand, at the methods of the homœopathic school. We will say a patient comes to you complaining of a dry cough. Instead of prescribing a cough syrup or a cough tablet, we try to select the similimum. We turn to the Repertory of Herings' Guiding Symptoms and under the heading of cough we find 414 separate symptoms with almost as many remedies. If the patient has a dry cough we can simmer it down to 120 symptoms. How utterly helpless the homœopath feels when some chronic dead beat stops him on the street and says: "Say, Doc, what's good for a cough?"

If it were not for a few well tried remedies the finding of the similar for the most common, every-day complaints would equal the tasks of Hercules. Is it a matter of surprise that many choose the shorter and easier method? Is not the use of our familiar and tried remedies often a form of empiricism and a menace to the homœopathic school? Do we not neglect the remedies less frequently called for?

The difficulty with the homœopathic school to-day is an embarrassment of riches. We are overburdened with symptoms. What we need is not more symptomatology, but an elimination of the useless, imaginary symptoms that fill our books. When I say imaginary symptoms I mean those symptoms which the prover would have had if he had not taken the remedy, as well as those symptoms due to expectant attention—that psychological state which is sure to result when undertaking a proving. Let the remedies be proven with proper checks, such as a record of the prover's symptoms previous to taking the remedy; a record also of the prover's condition of health and let a number of persons make the proving that they may answer as checks to each other.

A well equipped "prover's college" would be of more benefit to the cause of homœopathy than a half a dozen monuments or a thousand eulogies.

We need a longer and more critical study of materia medica in our colleges, and greater prominence given to the study of homœopathy by our medical societies. It is of more value to the average practitioner that he should know how to treat a common cold, a pneumonia or a case of cholera infantum than how to tie the stump of the appendix or do a hysterectomy. Our society programs are largely filled by our specialists who are making the societies a means of advertising.

These common, every-day topics are worn threadbare by discussion and exposition and yet they are the helps by which we cure our patients and make our bread and butter. Let us not speak slightingly of our specialists. They have done much to elevate our school in the estimation of the public, but our young men are wandering into the alluring fields of specialism before they have learned the rudiments of prescribing.

The day has long gone by when we can expect to excel the regular school by abuse or ridicule. The man that declares that cures are never made except by homœopathic means stultifies himself. We can only gain the ear of the public by curing more cases and by a better knowledge of homœopathic therapeutics.

The conditional survival of homœopathy depends therefore, upon,

1st. A greater simplification of our materia medica and its methods of application.

2nd. New and more extensive provings of our remedies with the elimination of useless symptoms.

3rd. Greater prominence given to materia medica and therapeutics in our colleges and societies.

4th. Education of the people as to the difference between the palliative treatment of the regular school and the deeper action of the homœopathic remedy; also as to the greater study and application required to choose the curative drug.

5th. A decent respect for the opinion of every man and not too great haste to condemn any method of treatment because its adherents can not speak the shibboleth of similia.

A CASE FROM PRACTICE.

E. W. BRYAN, M. D.
CORNING.

I was called, May twenty-second, to see Miss H., about twenty-six years of age, with dark hair, eyes and complexion. It was a new patient and an unexpected call. I had for many years known the father and often prescribed for him but had never known the balance of the family. The first view of patient revealed the fact that though I had a new patient it was no new case. I therefore began my inquiries as to the history of the case as well as family history, and pressed the same as far as prudence would allow. I was entirely unable to learn anything pointing to possible specific taint. Further examination showed less cause for suspicion. I learned that three or four years ago the young lady had suffered from inflammatory rheumatism, from which she had only partially recovered; although her previous health had been—as they expressed it—perfect. From the time of her recovery, to the extent of being able to leave her bed,

be about the house, ride and perform a little light labor, she had suffered from what seemed to them a very peculiar eruption called by various doctors skin disease. This, of course, was not a definite name, but I could not blame them for I could myself give it no more definite one. This eruption would appear on the back for a few weeks, get well and next appear on the face and so change from place to place, never entirely leaving one place until it had made a fresh appearance somewhere else. The rash generally came out in small pimples with light colored points soon resembling a point with pus, which was said sometimes to be the case, then dry, form a thin, brown crust, and soon the crusts would nearly cover the parts affected. They would shortly drop off leaving for a time slight redness of the skin where they had been. She had been under the care of various physicians for most part of the past three or four years with no definite improvement, and had in the past year taken a trip of some weeks to Mt. Clemmons, Mich., to try the virtues, if any, of baths from the waters of the somewhat noted springs of that locality. She returned slightly and temporarily benefited, if benefited at all. A short time before I saw her first she had returned from Philadelphia where she had been to consult Dr. John V. Shoemaker, who advised her to return to her home and gave her a prescription but no encouragement. The medicine prescribed irritated the stomach to the extent that she refused to take it. At this time I was called, found her emaciated, feeble, nervous, irritable and discouraged; her stomach refusing or rejecting nearly everything offered or taken, bowels constipated, seldom moving without a cathartic draught of some kind. Seldom got to sleep before three o'clock in the morning and then slept till ten or after. Her face was almost entirely covered with large pimples resembling small boils and the brown crusts previously described. The skin of the hands was very dark and shriveled, resembling those of a person eighty or more years of age. There were sores about the roots of several of the finger nails, which seemed to be loosening them and two or more were gone. It was unlike anything I had ever seen and only resembled by a couple of cases brought to mind of skin eruption produced by the extravagant use of iodide of potassium taken for asthma. I inquired if to their knowledge she had ever taken any of the above-mentioned drug, and was informed she had taken large quantities of it during her attack of rheumatism and that Dr. John V. Shoemaker told them that he thought she was suffering from a blood poison produced by it. She was at this time suffering from her stomach, which was sour, burning and distended by gas, all of these symptoms being aggravated by eating. Frequently severe vomiting followed ever so little food, no matter how carefully selected. Her tongue was deep red, shiny, smooth, though not apparently dry. She generally refused drink from dread of the distress produced. The quantity and appearance of urine was thought to be normal, and although requesting actual measurement for twenty-four hours and a sample from same to test, on each returning visit was told they had forgotten, each time informing me of its thorough testing at Philadelphia and its normal condition. I was myself thor-

oughly satisfied that the iodide of potassium was the cause of most, if not all of her present suffering and from that standpoint prescribed iodide of mercury, believing it to be as good an antidote as I knew. She commenced at once to improve, her stomach to bear food, her appetite and strength to increase, the pimples on her face to heal without the formation of crusts as before and the crusts already there to come off. In three weeks the face was nearly smooth, and the sores on fingers were healed, no new sores appearing on any part of the person. Patient greatly pleased and said she had no recollection of ever having felt better. I advised her to ride every pleasant day and enjoy all the open air she could without fatigue. From this time I visited her about once in three days and began to think I had a cure, but not so. The next time I called, reasoning from the advice given to take all the open air exercise she could bear, she with a party of others had gone camping on the bank of the river near by and left word to send her medicine to her. She was gone for about one week and when she returned informed me she had taken cold and was having some rheumatic pains in her ankles and toes, the toes soon began to swell and large cracks came between the great toes and the ones next to them which discharged an ichorous, watery fluid with an offensive odor; the feet swelled, were deep red and shiny with fine rash, which also discharged. The swelling gradually extended nearly to the knees. There was intense smarting and burning aggravated by assuming recumbent position, prohibiting sleep except when in the sitting position. By this time the suffering was so great that she refused to use the legs or feet at all and œdema soon became considerable. I tried several remedies, among them rhus tox., which seemed to most nearly cover the totality of symptoms and gave most relief; the rash and sores improved, but œdema increased, which I thought in large measure due to the sitting position. At this time I secured the services of a physician who made large use of massage, hoping to encourage absorption thereby. This treatment rapidly reduced the swelling of the feet and legs, but an aggravation of the stomach trouble immediately followed. From this time I feared we were getting too rapid absorption and made less use of massage with less stomach trouble. At this time I succeeded in getting the urine measured and a sample for test, and found the quantity a little more than one quart, sp. gr. 1035, and sugar by Whitney's test sixteen gr. to ounce. I did not believe this a case of diabetes, but charged the condition to the rapid absorption and one week later made another test (sp. gr. 1015 and not a trace of sugar by same test) and at the end of the next week found sp. gr. 1010, quantity about three pints, no sugar. The patient had been for past two weeks taking little other medicine than mercury. The sores on left foot and legs had healed, rash gone, color normal, and no œdema. The rash and sores of right leg also gone, but considerable tenderness and swelling still present. Patient could now lie down and sleep, walk with little assistance, ride several miles without fatigue and the improvement thus far has been gradual, but continuous.

A CASE OF LEUCÆMIA.

C. R. SUMNER, M. D.
ROCHESTER.

On August 3, 1898, Mr. J. H., a traveling salesman, called me up at midnight and requested an examination. I had been his family physician for several years, but his family being out of town, he had spent the evening with friends who remarked on his loss of flesh and strength and persuaded him to call on their physician, which he had done. He received a diagnosis of sarcoma, and immediate operation was advised or he would not live six months.

Examination showed considerable loss of flesh, dyspnœa on slight exertion, dull, dragging pain in left hypochondriac and lumbar regions, a rapid pulse and a high state of nervous excitement, due to the opinion he had received which had not allowed him to sleep and hence the midnight call. I found a solid tumor extending below the ribs on the left side. It slid under the fingers during respiration and I was able to make out a notch on its anterior surface and had no hesitation in pronouncing it an enlarged spleen, which relieved the patient's mind to such an extent that he went home and slept soundly.

The following day he called again and I took a specimen of blood from his ear and found that the white blood corpuscles were present in excess in the proportion of one to twenty of red. As he was to leave the city that day to join his family near Boston, I advised him, inasmuch as he had had two diagnoses, to consult the best authority he could find in the East. He did so and two eminent physicians of Boston confirmed my diagnosis of leucæmia.

Leucæmia is defined in Pepper's Practice as "a peculiar disease, assuming various forms, characterized by a persistent increase in the number of white blood corpuscles, associated with alterations, occurring either singly or together, in the spleen, lymphatic glands and bone marrow." Though this disease has been very carefully studied clinically, histologically, chemically and bacteriologically for over fifty years, we are still in the dark as to its etiology. The trend of opinion at present seems toward a micro-organic infection as the probable cause, though the particular microbe has not been isolated nor has the portal of infection been designated.

Two general forms of the disease are usually recognized, the lymphatic and the myelogenous. A mixed form is also mentioned and most cases are more or less of this kind as it is rare to find a pure case of either variety, the case taking its name from the predominant characteristics. My case was of the myelogenous form. Late in its course the cervical lymphatics became enlarged but not sufficiently to characterize it as of that variety.

October 3rd, Mr. H. returned to Rochester and a second examination showed the white corpuscles present in the ratio of one to ten. The spleen had increased in size until it reached to the level of the umbilicus below and to the right to the median line. He was still able to be about and attend to part of his business. His appetite was poor, pressure symptoms prominent and had a sensation of fullness after eating with occasional nausea.

From this time until January, 1899, the examinations showed a decrease in the number of white corpuscles until the ratio reached one to fifty. In January an attack of pneumonia was recovered from but the leucæmia was aggravated, the spleen reaching two inches below the umbilicus and one and one-half inches to the right of the median line. The number of white corpuscles had increased until the ratio was one to twenty. The liver was now enlarged perceptibly and there was tenderness of the sternum.

Early in July, just before he started for another visit to his relatives in the East, an examination showed the white corpuscles present in the ratio of one to four. He remained as well as usual until the seventh of August, when a copious diarrhœa persisting for a week closed the scene.

This case is presented to you not for the purpose of outlining any treatment, as treatment had absolutely no effect on the course of the disease, though carefully selected remedies did remove many troublesome symptoms and afforded much relief; nor to throw any new light on its pathology, but to call attention to its recognition and diagnosis. The importance of this was emphasized to my mind by the advice he had received to have an operation. In view of the tendency to excessive hæmorrhage in this disease and a record of twenty-three deaths out of twenty-four splenectomies performed for its cure, an operation should never be performed or advised for an enlarged spleen without a blood examination to determine whether it is due to leucæmia or some other cause.

REPORT

OF THE

BUREAU OF GYNÆCOLOGY.

"Vaginal Hysterectomy," - - - LIBBIE HAMILTON MUNCIE.
"Objection to Vaginal Section for Pelvic Disease," DEWITT G. WILCOX.
"The Homœopathic Prescription vs. Mechanical Intervention," GEORGE E. GORHAM.

VAGINAL HYSTERECTOMY.

LIBBIE HAMILTON MUNCIE, M. D.
BROOKLYN.

First, is it ever advisable? To prevent is nobler than to cure. Every honest physician seeks to save rather than to destroy. The life and the health of the body in general is superior to that of any of its parts; therefore important sacrifices are frequently demanded in order to secure health, happiness and even continuance of existence itself. Operative surgery is simply making the best out of a bad situation, and is invariably an apology for better work. Voiced, it would say to the object of its consideration, be it tumor, abscess, gangrene or other deserving pathology, "You are not only in a diseased condition yourself, but you are interfering with the bodily harmonies, and endangering life. You should have been prevented. I am unable to cure you; I must, therefore, kill you. You are too ill to recover, and are endangering the community of bodily organs of which you are a part; therefore for the sake of the others, I must destroy you. You must be sacrificed that the rest of the body may live." Although surgery is a destroyer of organic life, and buries its dead, yet in return it saves the living from infection. Capital surgical operations should be prevented; but until we are better doctors, some of us must be surgeons. As long as members are allowed to become gangrenous, surgeons must amputate them. As long as inflammatory process destroys the usefulness of one eye, and threatens the life of the other, offending the entire body, surgeons will be needed to pluck out the offending organ. This will be the case through the entire list of accessible bodily organs. The uterus is no exception. If it be diseased beyond repair, and by its removal life can be rendered worth the living, it should be doomed to extirpation just the same as any other offending organ.

Hysterectomy would be uncalled for if the true importance of the integrity of the uterus was better regarded. When weak and enfeebled, it should be strengthened; when tottering into the slightest abnormal positions it should gently but firmly be sustained in its proper place; when lacerated, repaired; when fires of inflammation have been lighted in its recesses, extinguished; when irritated, soothed; when sick, made well.

Since this is not the case, and it is a fact beyond successful controversy that the removal of the diseased uterus and appendages brings but light and happiness into the life where before had existed inexpressible suffering, it is conservative surgery that the patient be relieved of this diseased organ. Of what does it deprive her? The possibility of future motherhood, which in most cases has long been impossible. Every other possibility of a normal woman may be restored. Some of the happiest wives and mothers of my acquaintance are those who have been made well by means of this operation. There are five classes of uterine difficulties which at the present time call for vaginal hysterectomy: namely, cancer, fibroid degeneration, procedentia, tubal and ovarian disorganization, and old aggravated cases of irritability or atrophy with displacement and adhesions which have resisted all other treatment, and which produce unyielding and serious reflex disturbances.

In fibroma the vaginal operation offers such a wide range of possibilities that the old delusion of "their disappearance after the change of life" is rapidly losing ground, as indeed it should. Occasionally, after the menopause fibroma may atrophy, but only to produce greater and greater reflex disturbances, even to the end of life. It is no wonder that with the danger of the older methods for the removal of tumors, there was needed apparent reasonable excuse for letting them alone until life was in immediate jeopardy. The vaginal operation offers relief to those cases where fibroids are wrecking the entire harmony of the being, and still not presenting the dangers to life that would justify a laparotomy. It is in such cases that expectancy and the milder measures are often mischievous. Conservative treatment in a case may be radically surgical, when aside from surgery any other treatment is perilous and cruel. There are now on record many cases where a perfect cure has followed the extirpation of a uterus studded with many little fibroids, the largest not exceeding the size of a hickory-nut. Two cases now come to mind, who for fifteen years had taken every treatment that money and travel could procure, yet health was not regained until the removal of the knotty organ relieved all the mental and physical suffering. It is now over four years since these two operations were performed, and the patients are in excellent health.

Malignant degeneration, until within the last four years, was considered the only admissible cause for extirpation, and even then questioned. Now, the only expediency even in probable cancer, is the removal of the entire organ with its appendages, and that by the vaginal route, thus avoiding contamination of other tissue and allowing perfect drainage. There can be no middle ground upon this ques-

tion. It is here that the microscope comes in too late to be of service.

Many a valuable life has been sacrificed because the microscope or microscopist has been unable to detect the characteristic cell during the day of possible salvation. This question should be settled objectively and without regard to the often too late histological proof.

In all cases of long continued post-climacteric hæmorrhage with recurrent vegetations of the endometrium, with or without enlargement, undue or offensive discharge, and the characteristic "feel", the decree of ablation should go forth.

With tubal and ovarian disorganization, removal is demanded by almost universal surgical judgment of the age, but the removal of the uterus at the same time has been seriously questioned. Inasmuch as ovarian and tubular troubles are usually secondary to uterine pathology, and knowing that after their removal the uterus is no longer a source of either health, happiness, or comfort, but invariably detrimental, and as the removal of the uterus, ovaries and tubes by the vaginal route is safer and in every way more satisfactory than the extirpation of the appendages by the means of cœliotomy; I have no hesitancy in advising a hysterectomy in all cases where the removal of both ovaries and tubes is a justifiable or necessary proceeding.

In procedentia, where both rectocele and cystocele are present. By removing the redundant tissue covering the cystocele in continuity with the uterus and its appendages, and later on repairing the rectocele and perineum, leaving the lateral vaginal walls unmolested, the canal will be neither shortened nor obliterated, and at the same time the prolapse of the pelvic organs will be completely corrected.

Under what conditions is uterine extirpation admissible, if ever, in reflex disturbances, is the momentous question that confronts the surgeon? The first great question to settle in every case is the integrity of the woman's life. And second, can this uterus ever again be made available as a child bearer? Fortunately for us, this question is put into narrow boundaries by the limitation of age; inasmuch as the majority of those requiring this operation have reached or passed the menopause. With most of them it is a question of health betterment without regard to offspring. The third question should be, can this woman ever be well? Can she ever reach her best capabilities of wife, mother, and individual, while she harbors these diseased pelvic organs? And, fourth, has every reasonable and available means, surgical or otherwise, been employed to cure these distorted organs?

Vaginal hysterectomy including the removal of the tubes and ovaries has now become so easy of performance and so devoid of danger, free from shock, and attended with so little post-operative suffering, that it is destined to supersede suprapubic removal in all possible cases.

Entrance to the peritoneal cavity by cœliotomy involves greater shock, greater danger of sepsis, more excruciating suffering, and more prolonged convalescence than does the method under consideration; and has the added objections of possible ventral hernia and cicatricial disfigurement.

Each method, however, has its advantages and sphere of employment. Where it is possible and the operation advisable, vaginal hysterectomy is in every way superior. Tumors weighing three to four pounds can be successfully removed, showing that this route is wide in its possiblities.

Deciding then for the vaginal method, we have four recognized procedures, and to show the superiority of one over the other is one object of this paper. Of the four methods in vogue, each has its friends; namely, the clamp, the ligature, the cautery, and the Pratt method.

Edebohls, in one of the most explicit papers ever read on this subject, says: "The three methods of vaginal hysterectomy may be properly designated as the German, the French and the American. The Germans, almost to a man, practice serial ligation of the broad ligament. The prominent exponents of the French school, following the lead of Péan, swear by the clamp. Enucleation with simple ligation of bleeding vessels, although probably practiced in isolated instances elsewhere, first became established as a routine procedure in our own country where it has rapidly gained adherents.

To Pratt, of Chicago, belongs the credit of having by his practice demonstrated the practicability and value and by his teaching and writings disseminated a knowledge of the method which justly bears his name. Enucleation of the uterus with litigation of bleeding vessels only, appeals to my mind as a surgically ideal method in hysterectomy."

Of the clamp method little can be said in its favor; as in those exceptional cases which might require serial ligation of the broad ligaments. When there is malignancy of the parts, the cautery would be by far preferable, as it not only prevents hæmorrhage, but is reputed to actually destroy the cancer cell.

There is no excuse for ligating the broad ligaments in the average hysterectomy.

Some of the dangers of these former methods are: intestinal obstruction caused by the gut adhering to the margins of the wound or being included in the clamp or ligature. Peritonitis is frequently occasioned by the bruising and pinching of tissues by the clamp or ligature. Septic conditions are not uncommon in clamp, ligature, and cautery methods; as large masses of tissue are crushed, tied or burned off, injuring the nutrition of the parts. Hæmorrhage is occasioned by the clamp or ligature slipping, or by the blood vessels retracting into the tissues, or from sloughing.

The advantage of the Pratt method is superior in every way in the hands of a careful operator. First: large masses of sensitive sympathetic nerve fibers are not injured or destroyed, which means much to the patient, and to those who appreciate the power of this system, and who study its waste and repair. Second, there is little, if any, danger of septicemia and pyemia. Third, the removal of tubes and ovaries is not only possible, but easily accomplished. Fourth, the construction of the peritoneal floor is by this method rendered possible by coaptation of the severed margins of the peritoneum, thus confin-

ing the wounded surfaces to the vaginal vault, where they are easily accessible for purposes of healing, drainage, and cleanliness. This leaves the tissues as free after healing as though no operation had been performed. The tissues are left as near the normal position as possible when the uterus is gone; that is, where the uterine attachment of the broad ligament is severed from the uterus, it is brought together and its peritoneal borders of each side carefully coapted. Sixth, the accident of injury to the ureters is unnecessary and probably impossible by this method. Seventh, there is not encopsulated nerve fibers to give pain for months after the operation, and no permanent ligature to finally slough and form fistula, or to render long months of suffering. Eighth, the convalescence is almost invariably uneventful, and practically painless.

The average length of confinement to bed is two weeks. The final mental, moral and physical results are surprisingly happy and gratifying to both patient and surgeon.

DISCUSSION.

J. M. LEE: Dr. Muncie has written this paper from her own experience and has given us her views in regard to hysterectomy. There is little in it to criticise—in fact the paper might be taken as a whole and commended, but since we are here to learn, perhaps it would be well for the different views to be expressed. There are two points only which I will criticise: first, pinching of the nerve fibres by clamps or ligature, and second, application of the enucleation principle to advanced cancer of the cervix. My own experience, and that of the profession generally, I believe, does not coincide with Dr. Muncie's; pinching of nerve fibres does no harm. That it does is one of Dr. Pratt's theories which cannot be proven by practice. We might as well lay it aside and when we come to hysterectomy, let us combine the four methods, if necessary. When we do that we will be puzzled in certain cases to know how best to complete the operation.

The second criticism, as to the application of Dr. Pratt's enucleation principle to cancer of the cervix, especially when the disease runs out in the broad ligaments a little on each side of the cervix. Many such cases can be made to feel perfectly well for two or three years by appropriate and thorough operation, but Dr. Pratt's enucleation is of no service here. We must apply the clamp or ligature and take out all diseased tissue by incisions which are made one-half inch away from diseased tissue. It is not practical in these cases to employ enucleation or even tie each vessel as it is cut or before it is cut. One must ligate en masse or apply clamps freely.

I admit the former is the ideal way to operate; it is a beautiful theory; but we as surgeons have not sufficient skill to execute it to the satisfaction of ourselves or safety to the patient. For these reasons, then, I should say that we must make ourselves familiar with all the methods and when we come to a difficult case, apply the French, the Dr. Pratt, the German plan or all together, as may serve best in each case.

DEWITT G. WILCOX: I do not agree with the writer relative to the removal of the uterus when the tubes and ovaries only need to be removed, especially in young women. I think it has been demonstrated that the presence or absence of the uterus does play an important part mentally. Conservativeness, in the line of gynæcological surgery, so far as wise is the adopted plan at present. I think it has been demonstrated that the uterus does not degenerate nor is more likely to become diseased with the removal of the tubes and ovaries than without removal. In young women far removed from the menopause, I think it becomes an important factor. There are cases perhaps, if not in the majority in a large minority, wherein the menstrual function has remained constant after the removal of the tubes. The absence of the pelvic floor is a great consideration. With young patients the first question that is asked is, "Has it been necessary to remove the uterus?" I do not advocate the removal of that organ because the tubes and ovaries are diseased. They can be removed alone and there is no more danger of disease afterward if they are alone affected, I mean especially pus-tubes. In reference to the ligation of blood vessels and the use of the clamp, I would agree with Dr. Lee that you can lay down no specified rule for all cases. You must select according to conditions. When it comes to smaller fibroids or fibroid degeneration ligature is decidedly the ideal method. Neither do I think it is necessary to tie the broad ligaments in a ligature. I think it is possible after a little experience to cut down to the uterine artery and vein, and tie those two blood vessels by themselves. There are cases where you cannot dissect so closely; you must go wide of the mark, and where you cannot tie them off without the use of a clamp, we must classify conditions under which we meet them.

G. W. ROBERTS: I appreciate thoroughly that the limit of time in writing a paper is an element, and that the writer is obliged to make statements which are perhaps more sweeping than she would make had there been no time limit. I trust that is true, because I feel that some of the statements are more sweeping than the experience of the surgical profession at large would carry out. The paper advocates vaginal hysterectomy for five different conditions.

1st. As to Cancer. There can be very little argument here when we rule out those cases of advanced cancer which cannot be extirpated completely by the vagina. We admit that supra-pubic or abdominal hysterectomy is a hopeless procedure in these cases. Yet it must be said that there is a certain limit of time when vaginal hysterectomy has become impracticable and still it is possible to remove the uterus through the abdomen. There is a time when we cannot reach the disease through the pelvis, but having the advantage of sight as well as of touch, we can reach it from above. The writer says that supra-pubic or abdominal is immensely more dangerous than is vaginal hysterectomy. I do not think so, provided the surgeon is skillful as a general operator. One may acquire a skill with a single operation so as to remove the uterus through the vagina with much more skill than he can do an abdominal hysterectomy. In the abdominal method

we have the advantages of sight, of the Trendelenberg posture, and of dealing with adhesions and complications which arise in the worst cases in a more satisfactory manner than when operating through the vagina. Therefore I think it is preferable even in some cases of uterine cancer.

2d. Fibroid degeneration.—It is a shame to sacrifice the uterus on account of the presence of a few small fibroids; it is easy to remove these and save the uterus. It must be admitted that simple laparotomy, in good hands, has a danger line of two or three per cent., and as abdominal myomectomy is a simple operation it is a great mistake to remove the entire uterus per vaginam when it has only two or three little fibroids. It is not uncommon for a patient to be capable of procreation after the removal by myomectomy of a five pound uterine fibroma.

3d. Procedentia.—This, in extreme cases, is unquestionably well handled by vaginal hysterectomy, particularly in women past the menopause.

4th. Tubal disease means inflammation.—We admit that it has its origin in the uterus. The greatest danger of inflammation in the uterus is that of its extending into the tubes. As a rule, a mild degree of endometritis is not a serious condition, except in so far as it has danger of extending to the tubes. It is not the custom nowadays even when we have disease to remove these tubes. Save an ovary; save a portion of the tube; and there are many cases where these women have borne children with nothing to show that the after results of these cases are not as good as in cases of vaginal hysterectomy. We have all seen many women in whom there were exceedingly bad results from a vaginal hysterectomy, but these bad results we are not laying up against vaginal hysterectomy. When we can remove a diseased tube and save a portion of the other tube or save one ovary, we leave that woman in a better condition than had we removed the uterus, tubes and ovaries, as has been advised in this paper.

The fifth one is to me the most dangerous proposition of all; not dangerous because there is no truth in it, but it is dangerous because it is a difficult matter for us to decide when this indefinite condition referred to as "irritability of the uterus" calls for hysterectomy. The term "irritability" is vague, misleading, and of value only to act as a blind when the operator fails to make a definite diagnosis but must have an excuse to operate. As used in the fifth proposition the expression "old and aggravated cases of irritability or atrophy" is unnecessary, and even dangerous in that by its use we could justify ourselves for the removal of almost any uterus. I wish to raise my voice against the removal of a uterus of which there can be nothing more said than that it is irritable. I am still an advocate of hysterectomy, and perform the operation where there is good reason, but I do not think the mere condition of an "irritable uterus" or a "displaced uterus" is reason for so doing.

I agree with Dr. Wilcox that it is far from being demonstrated that the uterus is a useless organ after the ovaries and tubes have been

removed. The practical danger from uterine inflammation is extension to the tubes, and if the tubes are removed that danger is removed, and while in bad cases we make the habit of opening the abdomen and removing the body of the uterus, nevertheless they must be bad cases. When they are cases in which the endometritis has recovered or is capable of recovering, I save the organ.

DR. LEE: I agree with all that Dr. Wilcox has said and all that Dr. Roberts has said, and nearly all that Dr. Muncie has said. The truth is, the doctor had a well-nigh exhaustless subject to handle; it would take all the day to do it justice and bring out all the points. We cannot do that? She has put some things in there we do not believe. She has not amplified all the subject and could not. She has wisely left much for us to discuss. It makes a practical paper for us to consider and I am glad she prepared it in that way. I hope that every surgeon here will follow the good example that has been set by Drs. Roberts and Wilcox and will discuss every feature of the paper.

N. M. COLLINS: It seems to me that in choosing between these three methods of operating, their mortality should be taken into consideration. Now we all know that there are hundreds of different ways of preparing cat-gut, and that itself shows how uncertain we can be as to when the cat-gut is thoroughly sterile; we all know how easily a forceps can be thoroughly sterilized. Simply because we use forceps we do not need to put them on the whole broad ligament. But as far as the pinching of the sensitive nerve is concerned, there are very few who think that enters into the matter at all. On looking over the statistics of the above methods, it seems to me that the French method certainly has the most to recommend it. Péan's best record is one hundred and thirty-four consecutive hysterectomies without a death. I do not know Richelieu's mortality, but when I saw him he was operating on his one hundred and seventieth consecutive case without a death with the clamp method, and certainly we have no such record as that with cat-gut or with the enucleation method. I, for my part, feel that we can sterilize the forceps thoroughly while we are not sure of our cat-gut. Cat-gut is more apt to touch some contaminating thing than are forceps. It is more apt to carry the disease up, and there is very little sloughing afterwards, more with the forceps than with ligatures.

In regard to diagnosis, some speak as if it was necessary to take the uterus out in order to remove the ovaries and tubes. The first thing, unless the uterus is cancerous, is to go through the posterior cul-de-sac and examine both ovaries and tubes thoroughly before we think of taking out the uterus; if both are beyond repair some prefer taking the uterus out and some do not. I depend on the age of the patient. If beyond thirty-five years of age and both ovaries are diseased, I should say take it out even if the uterus appears to be healthy. A uterus of that sort, even if it looks fairly healthy, is better out than if left, especially if there be a backward displacement of it. The forceps are certainly much quicker than the ligatures. The ligatures are more apt to slip and the mortality is much less with forceps than with enucleation.

JOHN L. MOFFAT: Has any one here used Dr. A. J. C. Skene's electro-hæmostat? As an outsider in such work it strikes me as marking a great advance in such work as hysterectomy, etc. It is not a cautery so much as the desiccation of the tissues included, sealing the blood vessels and destroying all germs in the band of tissue; it leaves no cicatrix that will contract. A modification is somewhat like the blunt Paquelin cautery point.

L. H. MUNCIE: I would not be understood as recommending any other than the cautery for cancer. It now appears that in this nineteenth century will be developed that which is destruction to the cancer cell as is claimed for the galvanic cautery; therefore it is important to use no other than the cautery. A necessity for a hysterectomy or ovariotomy in a young girl is deplorable, and shows neglect of her case in its early stage. Although often done, it is very seldom necessary; but when necessary, the work can often be done by the vaginal route. With a young girl who has an ovary sick enough to be removed, there usually exists a retroflection of the uterus which must be corrected in order to cure the case. They object to a laparotomy and it is dangerous.

We have therefore made an instrument for fastening the uterus to the abdominal wall. It amounts to ventro-fixation without opening the abdomen. It has been used in six cases—four by ourselves and two by another surgeon. This operation has not only given immediate relief, but the final results were excellent. In some of these cases, the greater part of one ovary was removed, the remaining portion taking on a healthy condition so far as can be judged by the patient having good health.

I hope that my paper did not hint that I was in favor of making operations for the removal of the ovaries and uterus on young girls. As a rule, those requiring hysterectomy are approaching or have passed the menopause. Every other available means must first be tried before ovary or uterus should be removed in the young or old. If I did not make this strong enough in my paper, I want to do so now. I thought I did.

In regard to small fibroids, they also can be removed through the vagina. A young girl does not want to have her abdomen opened, nor does an old girl. She will wait every time. In operating through the vagina, there seems to be little shock; you can remove tumors, pulling the uterus down posteriorly or anteriorly, relieving retroflexion and anteflexion which will do much mischief, etc. The cases of small fibroids which I related were elderly ladies who had been troubled for years, no treatment relieving them. This class of cases, small fibroids, are just the ones that make life miserable. I have removed the uterus from several ladies of seventy and over seventy and they have hardly seemed sick.

There is nothing nobler or grander than motherhood. When a hysterectomy is called for, the uterus has already become too sick to serve. A woman is perfectly normal in every other function after this operation.

Dr. Roberts, you have been talking "irritable uterus" in regard to myself for I don't know how long. I have heard it in Chicago, all over New York State and up in Connecticut. You did not listen to my paper. You simply heard what you were listening for—"irritable uterus." Please let me read just what I said about "irritable uterus", and not uteri, and I want this settled now, and then we will be good friends. "Old aggravated cases of irritable or atrophied uterus, with displacement and adhesions which have resisted all other treatment and which produce unyielding serious reflex disturbances." I know it is a hard and long sentence, and when I wrote it, I thought of you and knew you would hear only two words—"irritable uterus."

Somebody said it requires no skill to do a vaginal hysterectomy. I emphatically deny that. Three surgeons, five years ago, came to our sanitarium to see a hysterectomy by this special method. They came the second and third times to see the operation before they undertook one, and yet they had been skilled abdominal surgeons for years. The eldest one, an author of one of the best text books on Diseases of Women, remarked that it took very much more skill to do a vaginal hysterectomy than a laparotomy, and one of these surgeons, when he undertook it, wrote me a letter that he was unable to follow the steps although he had a simple case, and he wanted to see one more operation. Cat-gut is simply the peritoneal tissue of lamb. What is purer or cleaner than lamb? And there is no reason why it cannot be properly prepared, and no reason why it cannot be just as clean as silk or silver.

DR. LEE: Will Dr. Muncie please describe the method of removing the uterus by the new cautery method?

DR. MUNCIE: Dr. Burns' method is simply that of using the little curved cautery, very much the same as the Pratt spud, for hysterectomy. The uterus is enucleated or any other portion of the tissue is taken away with this little cautery knife. We had a case last week where we could not apply the Skene method, which calls for clamps, but with the Burns method there is simply a little spud, and you can peel around diseased tissue in a small space. The Skene apparatus costs fifty dollars; it is used with a galvano-cautery storage battery.

OBJECTION TO VAGINAL SECTION FOR PELVIC DISEASE.

DEWITT G. WILCOX, M. D.
BUFFALO.

While colpotomy (or vaginal section) has a very useful and indeed necessary place in pelvic surgery, yet it should not be made to do service for that which it is in no wise fit. Its special and limited function is the rectification of lower pelvic abnormalities. Diseased organs situated in the upper pelvis cannot be treated with precision and thoroughness through a vaginal incision. A question next to be settled is, "What organs are situated in the upper pelvis?" When in their normal position, the ovaries and tubes lie on a level with the upper edge of the broad ligaments; this edge is slightly above the level of the fundus of the uterus, and hence the tubes and ovaries are well up to the brim of the pelvis. When however the tubes are diseased, either through inflammation or through distention with pus or serum, they vary greatly in the altered position they assume. Not infrequently do they become adherent to the bladder, to the iliacus muscle, to the fundus of the uterus or to the intestines, which hold them high up in the pelvis. If we could rely upon their dropping into the posterior cul-de-sac, as they are more generally inclined, then we could with more earnestness bespeak for vaginal section a preference.

The uterus is properly a lower pelvic organ, and when not too much enlarged by fibroid or other growths, is best removed per vaginam. Furthermore, if the uterus be retro-displaced with firm adhesions, these latter can be broken up a little more readily by a vaginal section. Again, if there be one or more abscesses in the lower pelvis, particularly in or about Douglas' pouch, they are more effectually drained by this same method. I further admit that there is a small percentage of pus tube cases and ovarian cysts which can be removed by colpotomy. But these cases must be comparatively free from adhesions and well down in the pelvis to admit of the said procedure.

Some of the objections to colpotomy may be thus enumerated:

First—It allows but a limited field for exploration, which may result in failure to discover certain abnormalities that should be corrected and which would readily be discovered by an abdominal section. Second—If loops of intestine be adherent to structures undergoing removal, there is a greater danger of tearing said intestines than by the abdominal section, simply because the work of separation must be done by touch unaided by the eye. Third—If such injury does take place it is quite likely to be overlooked or, if discovered, requires an abdominal section to correct it. Fourth—There is an ever constant danger of injury to the bladder and uterus, which danger plays a very insignificant part in abdominal sections. Fifth—The opera-

tion is unscientific, because it is a blind groping after diseased conditions, which is entirely unnecessary so long as there is a better method where exactness and thoroughness are possible.

I am inclined to think the operation is more popular with surgeons who have had a limited experience in abdominal sections and for that reason prefer to assume the lesser risk of colpotomy. The fact that it is a less dangerous procedure is a very poor argument in its favor, so long as the diseased conditions cannot be effectually reached and removed. In support of the foregoing, I would say, there are a number of cases on record, to which nearly every surgeon of large experience can testify, wherein it has become necessary to open the abdominal cavity for the completion of work undertaken and unfinished months before by the method of colpotomy.

I would not be understood as an enemy to colpotomy, when that operation is limited to its special sphere; for I have made and am still making the operation frequently and shall continue so to do, as long as it proves satisfactory. But I do maintain, and that stoutly, that it is not the ideal operation for the removal of diseased tubes and ovaries, particularly when extensive adhesions are present. I make this statement, not through theoretrical objections, but after having given it a fair trial in some half dozen cases.

When beginning my services for this year at The Erie County Hospital I determined to test well colpotomy for pus tubes. We have at this hospital a large number of cases of gonorrhœal and catarrhal salpingitis. The majority of the cases are young women who do not seek aid until driven so to do by pain and weakness; from June 1st to September 1st, I had twenty-two such cases. The first four I took just as they came, without any selection and made a colpotomy in each.

The first case was a well marked, double pyo-salpinx, early stage with few adhesions. I had no difficulty in bringing tubes and ovaries into the vagina through the section made in Douglas' pouch. Upon one tube I opened the sealed fimbriated extremity, washed out tube with peroxide of hydrogen and pushed it back into the pelvis without removal; the other side, being more degenerated, I removed. The patient made a rapid recovery and has since been well, having no pain in the replaced tube.

The second case was similar, save that I did not evacuate the tube, as in number one, but removed both right and left. Each operation required fifteen minutes for its performance.

The third and fourth were difficult cases; dense adhesions, large tubes, much bleeding, and required more time than any of the subsequent abdominal sections for the same condition, namely, forty-five minutes.

When I came to the fifth case, which showed quite a bunch on either side of the uterus, I felt that I had given colpotomy for pus tubes a fair trial, and returned to abdominal section.

In this particular case (the fifth) the tubes were high up in the pelvis, densely adherent to loops of intestine, which required the most careful dissection under close inspection, to liberate. Had colpotomy

been attempted in this case, it would have resulted in failure and necessitated an abdominal section to complete. The remaining seventeen cases of the twenty-two were operated upon by opening the abdomen in the usual way. In all of them one or both tubes were found diseased and removed. The longest time required for any one operation was forty minutes; the shortest, twelve minutes. There was no death in either series, colpotomy or abdominal section. One patient required a second operation because of a pelvic abscess which was drained per vaginam, after which she made a good recovery. The colpotomy cases made more rapid recoveries than the abdominal sections, because we could trust them to sit up in bed at an earlier period.

I find that shock is directly in proportion to the duration of the operation, and in those cases of abdominal section where the operation did not exceed fifteen or twenty minutes there was no more shock than in the vaginal section. Incidental to this question of shock, I should like to digress sufficiently to say that the duration of an operation is an exceedingly important factor in influencing shock. I am convinced that in major operations, where vital viscera are exposed or large nerve trunks injured, shock is in proportion to the time the patient remains under an anæsthetic; hence it is highly essential that the surgeon should develop speed together with precision. I trust I may be pardoned for mentioning a personal achievement in this connection, which I do in illustration of the above statement. While in Philadelphia, on my return from the American Institute, I visited the Philadelphia Hospital and was there told that a certain surgeon of the staff had a few days prior opened the abdomen, tied off a bleeding ovarian artery and sewed up the wound in ten minutes. Upon my return home I found awaiting me a patient with a small ovarian cyst. There seemed to be no adhesions and I considered it a good case upon which to make a trial of speed. When the operation was undertaken one witness stood watch in hand and made this record. From the moment of taking up the knife until the ligation of the pedicle and complete removal of the cyst, four minutes; time of sewing up the abdominal incision, six and one-half minutes; total time from start to tying of the last suture, ten and one-half minutes. The abdominal incision was sewed first, by two through and through silk worm sutures; second, by a continuous peritoneal suture; third, interrupted mattrass sutures for aponeurosis. There was absolutely no shock, little vomiting and patient felt like sitting up in three days; this in spite of the fact that she was weak and anæmic to begin with.

Colpotomy has a useful but a very limited scope as a means of exploring the lower pelvis and in this capacity may sometimes save an abdominal section. In illustration thereof, I will cite the following case: A middle aged woman came to me, suffering from pelvic pain. She was very stout with a fat abdomen, which made it difficult to outline anything by the bimanual method. I could distinctly feel a tumor in the pelvis, pushing down the posterior vaginal vault, but whether cystic or fibroid, uterine or ovarian, I could not determine, hence made a colpotomy to decide. I found there a cystic tumor filling up the

entire pelvis; it was so low down that I readily pushed into the tumor a Wells trocar, evacuated it, pulled out the sac, tied off the pedicle and thus made an ovariotomy per vaginam. I might wait six years before I found another similar case, and make a dozen colpotomies before I could remove one in like manner. Again, a case presented with a boggy mass in the posterior cul-de-sac, wherein the history given had a suspicion of ruptured tubal pregnancy; colpotomy revealed large blood clots, placental tissue and the debris of ectopic fœtation, all of which was easily cleared away by this method.

In further substantiation of my position regarding the limited field of usefulness of colpotomy, I will quote from a few writers of note: In a personal conversation with Dr. Joseph Price, of Philadelphia, while visiting his hospital in June, he expressed himself in the most bitter denunciation of vaginal section for pus tubes; particularly in those cases where the uterus was removed for the purpose of draining the tubes, but the tubes themselves left behind. He limited colpotomy to the draining of pelvic abscesses and making vaginal hysterectomies, and then ended by saying he preferred abdominal section for hysterectomy, anyway.

Dr. Howard Kelly says in his recent work (page 222, second vol.): "The first cases in which I resorted to vaginal puncture were those which came to me in such a critical condition that radical operation was impossible, and the evacuation of the pus through the vagina was done simply as a temporizing method, with the view of performing a more radical operation later, when the patient had sufficiently recovered to permit it with safety." He further speaks of the gratifying method of treating abscesses in this way, but seems to limit his operation entirely to what he is pleased to call "vaginal puncture."

In the Year Book of '98, Coe states that "Those advocating the vaginal method of operating have during the past year notably receded in their claims and are returning to the abdominal method."

Again, in the Year Book of '99, in a quotation from the Chicago Medical Record, 1898, Cragin says that in his hands the vaginal operation has proved of great service in cases of pregnancy in which the parturient canal was blocked by tumors. According to his experience, the vaginal operation has proved a great boon in three groups of cases. Only cases in which the removal of the tubes and appendages are indicated. Two cases in which exudate indicates the necessity of drainage without removal of the organ.

In the American Gynæcological and Obstetrical Journal for June, Dr. Lapthorne Smith of England says, "The removal of pus tubes by the vagina is more difficult than by the abdomen, in all cases except those in which the uterus is removed at the same time;" but he adds, "The vaginal method of freeing the retroverted adherent uterus is on the average more difficult than the abdominal method."

In the same journal for April, A. J. Puls says, "It is impossible to sharply define the field limited to cœliotomy or to colpotomy. Those following the vaginal method unfortunately extend the operation to the entire field of intraperitoneal surgery, and on this account the

operation has fallen into some discredit, as in order to accomplish its purpose the uterus is often sacrificed or mutilated and the intestine perforated or otherwise injured. Often the operation has to be abandoned on account of firm adhesions or excessive hæmorrhages, and a suprapubic incision has to be made."

John W. Whitbeck, in the Medical Review of March, 1899, also wishes to prove that the surgeon can do more and better work in the pelvis and abdomen by operating from above the pubis than below it. The rapidity of the vaginal operation in certain cases, the drainage, the repair, the absence of scar or hernia, are not to be disregarded, but while diseased organs can be removed through the vagina the same organs can be taken away through an abdominal incision, and if any complications exist the complexity can be more correctly, more safely and more conservatively treated from above than from below. The vaginal route, with its limited inlet, its deep, dark subway, is not, cannot be, the wide open field which the abdominal route is, and therefore should not be substituted for that great highway, but should be reserved for special and appropriate cases."

As a means of draining the pelvic cavity, vaginal section is ideal and it is very easy to establish this means of drainage after an abdominal section. In the removal of large tumors with dense adhesions or in cases where I fear serious evacuations of the peritoneal cavity, I invariably employ vaginal drainage. It takes but two or three minutes to insert this drainage after the following method: Trusting the vagina to be well cleansed before the operation, I push my finger into the posterior vaginal vault, introduce a pair of sharp pointed scissors, using the inserted finger as a guide, and force them into the posterior cul-de-sac. The handles of the scissors are then opened wide and a piece of gauze in the jaws of the uterine forceps is pushed through the opening from the abdominal side into the vagina and drawn out together with the scissors still open. This gives all the drainage necessary and allows a complete closure of the abdominal incision and gives absolute control of any accumulation in the lower pelvis.

Were I called upon to state briefly the scope of colpotomy, I would say it is the ideal method of pelvic drainage. It is an excellent method for vaginal hysterectomy and it is sometimes useful in exploring the lower pelvis, but that it is unscientific for the removal of pus tubes, ovaries or ovarian growths.

DISCUSSION.

W. L. HARTMAN: I believe, as Dr. Wilcox says, that the vaginal route in the majority of cases is the most unscientific way. I realize that the shock is much less in doing the work through the vagina than opening the abdomen, and we say that we prevent ventral hernia. But it seems that we get troubles in doing work through the vagina that may be as bad as ventral hernia. Now in removing the ovary (perhaps a good size ovary) and cyst. If we were sure before we started

that we had an ovarian cyst without adhesions it would be very nice to go in there, puncture and pull the sac out and tie it off, but there is one more thing to consider about that. There is no one here among the men who do good work and who have had very much experience but will say that we are liable to get more or less trouble from adhesions, the intestines adhering to the stump, now and then causing us trouble later on in life. If you are going through the vaginal route it is not an easy thing to cover up the stump; if you are going through the abdominal route, you can always cover your stump thoroughly and prevent anything like adhesions. In going on to pus tubes, for instance, we do not as a usual thing get pus tubes until adhesions form, and the moment these adhesions form and the intestine is adherent to it, are we justified in pulling that down and dissecting that pus tube from the intestine and not covering up the denuded surface? We are not, because we are liable to have following that the adhesion to any portion—to an intestine or what not—and we are having more trouble than before. Why? The next thing we fear is obstruction of the bowels within forty-six hours or say a week. If you had gone by the abdominal route you could have pulled it up, have done a scientific operation, covered up the denuded surfaces and feared no trouble from adhesions or following obstructions. As to the rapidity of the operation. I should like to say to Dr. Wilcox that the rapidity of operating is brought about by the experience the man has had. Dr. Collins said that the French were so successful in doing work through the vaginal route, simply because they are men who have done thousands and thousands of cases; if I remember right, Richelieu had four thousand operations. There are very few in this country who can ever hope to attain that experience in operating. Of course, we should be proficient, but I do not care if he has had ten thousand, if he has a pus tube up there and cannot get hold of it and cover the raw surface, he is no better off than a man who had but one case. Therefore the one thing, rapidity, to prevent shock; but what is the after result? I certainly must congratulate Dr. Wilcox on his rapidity in opening the abdomen and doing an ovariotomy. I believe that where you have a great many adhesions to deal with you can do the operation more rapidly by the abdominal route than you can by the vaginal and cover up your tracks as you go, which is not a very easy thing to do when working through the vagina. That is the experience I have had. Then we must take into consideration when we do a case of that sort, the length of the vagina and the calibre of it. If we have a small vagina to deal with it is almost impossible to do the work by that route, if we have any complications whatever. If we have a long vagina, we have the same trouble to deal with. In a case not long ago for Dr. Barnes the ovary had gotten on top of the uterus; how could this have been operated per vaginam? It could not unless denuded surfaces were left uncovered. In the majority of cases I should condemn the vaginal route. I operate cases of tubal pregnancy where I can through the vaginal route, but in the majority of these cases it is impossible to work that way. If you start for tubal

pregnancy through the vagina you finish by the abdomen, especially if you encounter a troublesome hæmorrhage.

G. W. ROBERTS: I doubt the importance which the author assigns to rapidity in operating. There is great danger in the attempt at rapidity of not being entirely accurate or thorough. My belief is that shock is due more to the method of operating and of administering the anæesthetic than to the length of time consumed. Unquestionably the methods of giving the anæsthetic, employing large quantities of ether (one of the worst results of which is the lowering of the patient's temperature from the rapid evaporation of the ether), is conducive to shock; also loss of blood and exposure of the abdominal contents are important causes. But if we operate in the Trendelenburg posture and keep the upper abdomen thoroughly isolated from the pelvic portion we avoid shock. It is not at all uncommon in difficult cases of pus tubes for us to keep patients under the anæsthetic for two hours. It is not at all uncommon for that same thing to be done in complicated cases of fibroma. I saw Kelly but a short time ago have a patient under an anæsthetic four hours and a half in removing a fibroid tumor, and he is a man whose great ability we all recognize and admire. I think that we should bear in mind a recent advance in combating shock, which is the leaving in the abdomen of one or two quarts of hot saline solution. My personal experience has been that when I have poured into the abdomen a couple of quarts of hot saline solution and, instead of putting my patient flat in bed, placed her with the hips very much elevated so that the body is at an angle of 45°, I not only lessened the shock and found it practically disappear from abdominal operations, but that I have been able to do away with drainage to a very large extent. I think it is a year since I used any sort of abdominal drainage, except the "intra-abdominal drainage" just described. I call it so (it is not my term—it was published in the "Ananls of Surgery" a year ago) because the putting into the abdomen of a large amount of fluid dilutes any infectious material and the posture of the patient permits the fluid to run to the diaphragm; the fluid is rapidly absorbed because the lymphatic spaces in the diaphragmatic peritoneum are very much more numerous and are larger than those of the pelvic peritoneum.

L. H. MUNCIE: Whether shock is due to long continued operation or whether it is due to the anæsthetic, is certainly a very important question. It seems to me that it must be due to the anæsthetic, and I would like to ask Dr. Wilcox if his patients are given the anæsthetic by a competent anæsthetizer, or by the general hospital anæsthetizer who has had little experience. In our hospitals the anæsthetic has to be administered by one who is learning. The patient is usually given five or six times more than she needs. In connection with this, I have brought to mind our experience in our Island Clinic for three successive years; each year we have had twenty-six patients, demonstrations have been made to the class and patients have been under an anæsthetic for a long while, unless there was a weak patient, and in the three consecutive years with twenty-six operations each there was but one case of shock, which was slight.

N. M. COLLINS: I can't say that I agree with Dr. Wilcox fully. If he had faith in doing the work he would not stop with pus cases. Dr. Polk also says that where he used to open the abdomen five times he now does it four times through the vagina with much less risk to the patient. He admits that it is harder for himself, but he says the patients get along much better and the risk is much less. Baldy of Philadelphia, in reviewing the work on gynæcological lines in the Year Books for 1898 and 1899, both times says that the vaginal route is fast gaining ground, probably on account of the lessened mortality; I think that if Doctor Wilcox will take pains to look up the statistics by the vaginal route and quote a few more men, he will find it is going the other way rather than by the abdominal route.

Martin of Berlin, probably the best abdominal surgeon in Europe to-day (a man who can do an abdominal section in five minutes and close it up), is quoted as doing all his pus-tube work and nearly everything in the pelvis, through the vagina. Certainly so far as I can find, the work on the vagina is on the increase. If I find an adhesion and it does not break up readily, it is a very easy thing to open up the abdomen with no very great risk. It takes a very short time to change. If you find a pus-tube packed up so high that you cannot get it down without breaking up the adhesion you can go over to the abdominal route. You want to make a good large incision in the posterior cul-de-sac and have suitable retractors and your work is just as plain as outside, the mortality is practically nothing, and as to the length of the time they are in bed, I have known a number of cases to be up on the tenth and walking around on the eleventh day. I had one patient carry a small tray to another patient on the twelfth day; this patient had one ovary removed and the other ovary repaired, one whole tube removed, and of the other the end opened and stitched together. It is surprising to note how much is done that way if you have faith in the work, but if you fear that you are going to do injury there, you leave half and you might as well have gone the other way. If you see much of that work and know what can be done you will do more work that way—at least four out of five cases can be operated more successfully through the vagina.

DR. WILCOX: As to the administration of chloroform, unfortunately we cannot always regulate that matter as we would like. In private practice I have had an experienced man to give it, but in hospital practice I must of necessity take the man provided by the hospital who is not always experienced. If we could regulate this matter and have an experienced chloroformist every time I should not feel as nervous, but we must make the best of circumstances. I agree with Dr. Muncie that the method of administering chloroform is a very important one and one that enters into the question of shock. When I have an experienced man to give small quantities and hold the patient under properly I can operate with much less anxiety. When the operation takes over an hour's time I am very anxious, for after that time the shock increases very rapidly in proportion to the time then extended. I would not be misunderstood as saying that thoroughness should be sacrificed for rapidity, but as we gain in

experience and gain increased rapidity we are aiding patients to a rapid recovery as we can make the time shorter. Dr. Collins thought that the method was just as easy and plain through the vagina. If the adhesions are there we cannot get the tubes down as easily as we can by the abdominal method.

THE HOMŒOPATHIC PRESCRIPTION VERSUS MECHANICAL INTERVENTION.

GEORGE E. GORHAM, M. D.
ALBANY.

In August, 1897, I saw Mrs. D. and received from her attending physician the following history: Age, forty-five; mother of three children, youngest fourteen years of age. For two years last past menstruation had been profuse and in January preceding the August in which I saw her she began having pretty sharp hæmorrhages from the uterus which had continued more or less steadily until I found her prostrate in bed, extremely anæmic, pulse easily compressible, of small volume and beating one hundred and fifteen times a minute. Two sharp hæmorrhages had occurred during the two weeks immediately preceding. The voice was weak and husky from loss of blood. A digital examination revealed a soft and gaping os and evidently an enlarged uterus. I advised an immediate curettement. The attending physician consented, but expressed the opinion that the operation was unnecessary and that homœopathic medication would cure her, notwithstanding the fact she had been under his constant care for eight months and had gone to the verge of the grave with hæmorrhage whilst sabina, ipecac, crocus, china, trillium, hamamelis, geranium maculatum, secale cornutum and other drugs had been given, each as they were seemingly indicated. The next morning I carefully curetted, washed out and packed the uterus with iodoform gauze. There was no more hæmorrhage, the patient recovered and remained well until November, 1898, a period of fourteen months, when the hæmorrhage returned and the operation was repeated with the same salutary result.

In 1894, I made a journey into the country to see in consultation a supposed case of cancer of the stomach. The patient had had constant nausea, night and day, with very frequent vomiting for six months. She was weak and emaciated, nervous and irritable from loss of sleep, the nausea preventing sleep. Save the sallow complexion and the vomiting no objective or subjective symptoms of cancer could be found. In the os uteri was found a fair sized mucous polyp, which I twisted off and made an application of tincture of iodine. The vomiting ceased immediately and the patient made a prompt and complete recovery.

Some years ago I had a patient who came to this city from Boston. Two years after the birth of her first child she supposed she was pregnant, but her flow soon returned accompanied by considerable abdominal pains. For three months she continued to have at intervals severe abdominal pains, some soreness and a scanty flow which was supposed to be an irregular menstruation and the abdominal pains were supposed to be neuralgia of the bowels. During the first eight weeks of her illness she was under the care of an eminent old school specialist. She then called a noted homœopathic physician who kept her in bed six weeks and prescribed most accurately the indicated homœopathic remedy. There being no improvement I was asked to see her and, believing a blighted ovum to be in the uterus, I advised an immediate curettement, which was done with the result of removing a little mole and immediately curing the patient.

I have no reason to believe that this experience is unique and therefore, to open the discussion of the subject before this bureau, I assert that too much confidence is often placed in homœopathic medication in diseases of the female pelvic organs, and that local and surgical treatment should oftener be restorted to. In two of the cases cited, long and faithful trials of homœopathic medication had been made and had the cases been left in the hands of those who believe so deeply in the efficacy of homœopathic treatment the results must have continued, in my judgment, unsatisfactory.

DISCUSSION.

G. W. ROBERTS: The recital of cases of extra-uterine pregnancy is of great value, because these cases are comparatively frequent and it is a comparatively rare thing that we make an early diagnosis; yet it is very desirable that we do so. In the first place, the difficulty of early diagnosis lies in the fact that an early diagnosis must be a very early one in order to be of any value, and the diagnosis at that time rests largely upon the early diagnosis of pregnancy. It is an unfortunate thing that such a common condition as pregnancy does not often come to us for early diagnosis, and, as a rule, we are likely to be a little lax in our examination of cases. I think the doctor said that at the second visit, twenty-four hours after the first, he found the patient suffering from a sharp pain which came on suddenly and extended all over the abdomen, and accompanied by sensitiveness and distention. These symptoms as described in the paper could only mean one of two things—a rupture of something into the abdominal cavity or else a gradual leakage, and either of these conditions should in another case relegate the case to a surgeon. They are distinctly symptoms of some surgical condition, and when in addition the patient has skipped one or two menstrual periods one becomes at once suspicious. The shreds to which the doctor has referred present a characteristic appearance. Under the microscope it is comparatively easy to make the diagnosis between those shreds which are cast off with a membranous dysmenorrhœa and the shreds cast off on account of the presence of extra-urine preg-

nancy. Very frequently these pieces of material come away not as shreds but as entire casts of the uterus. Not very long ago I had three cases of extra-uterine pregnancy inside of thirty days and from two of these cases there came casts of the uterine cavity so there was no great chance of error in diagnosis. Therefore, these shreds coming away should always be put in water spread out and carefully examined. Unquestionably some cases of extra-uterine pregnancy recover without operation, but they are very much more safe if they are operated upon. As to operation itself, the only thing I wish to say is that one practical point at least has shown itself in the cases which I have chanced to meet. Many of these cases are extremely exsanguinated and it is essential that the abdominal cavity be emptied of clots as soon as possible and the bleeding points caught. Now as these patients are lying in bed the pelvis lowest, therefore when hæmorrhage occurs the clots occupy the pelvis while the bloody serum occupies the upper portion of the abdominal cavity. Now ordinarily we open the abdomen with the patient in the Trendelenburg posture, but it is better under these circumstances to make the long incision with the table so tilted that the pelvis is lowest. If this is done the fluid blood and serum flows out at once and if the table is then quickly reversed to the Trendelenburg posture the clots are easily removed from the pelvis and the bleeding point exposed. On the other hand if the incision is made while the patient is in the Trendelenburg posture the fluid gravitates to the diaphragm and is totally hidden by the inflated intestines which float upon it, the operator is ignorant of the existence of this fluid and cannot understand why the intestines cannot be kept out of his way. This very hindrance may cost the patient her life.

Drainage in these cases is worse than useless, and the abdominal drainage tube is a positive danger.

D. G. WILCOX: I think there was a great deal to indicate that it was a tubal pregnancy. For we have it in the doctor's own words; just listen: "I was called in to see Mrs. ——. She was suffering from very severe, sharp pains, extending up to the abdomen. She informed me that she had not been menstruating for two months and took medicines to promote the flow." I believe that it is possible for every practitioner to recognize a case of tubal pregnancy in the early stages—five or six weeks—and recognize it before rupture, because the symptoms are characteristic and with a little observance of the symptoms it can be done every time. In the first place there is that severe, sharp pain which comes on suddenly. If you stop to think you will recall there is scarcely another condition wherein the pain is of the same character. In colic it is different, because it is in the general abdomen; in gonorrhœal salpyngitis it comes on more slowly and is attended with temperature and high pulse, but in tubal pregnancy our patients will tell us every time that they have been feeling perfectly well and were suddenly attacked with a pain on the right side—(seventy-five per cent. of the cases are on right side)—that makes them feel obliged to lie down. They have generally a little suspicion of pregnancy and they may not have gone over their menstrual period

more than a week. With that indication of sharp, sudden pain very intense, low down in the abdomen and returning after an interval of three days or week we should be led to make a vaginal examination. Should we do so and find an enlargement on one side or the other of the uterus, we have there important symptoms which need to be verified only by delayed menstruation. If she has a salpyngitis, she will tell you that she has had a pain there for a year or so, but if she tells you that she has had no trouble heretofore, but that this came suddenly and there is the plain enlargement, we can put it down in ninety-nine cases out of a 100 we have tubal pregnancy. If we can do that we can save the patient much suffering and danger. If we wait for more indications, something upon which to make the diagnosis more positive we will get into difficulty. I had a case of a woman who was taken with this same sharp pain; she was faint, had to lie down. She sent for her physician and upon the mere fact that she had a sharp pain he diagnosed it as stone in the kidney and gave her a morphine injection and told her to be quiet. She had periods of pains for two weeks. She changed physicians—sent for a man from Buffalo who saw her and diagnosed appendicitis, because the pain was more general. She had frequent attacks, missed a menstrual period by a week, which should have made him very suspicious; still he held that it was appendicitis. He called in one of our physicians who said that it was ovarian irritation, but he failed to recognize tubal pregnancy. When I saw her I diagnosed the condition because of the sharp pain, irregular flow (and delayed menstruation), and a lump on right side. I operated and found a six-weeks' old fœtus in an unruptured tube that would have burst in a few days and then we would have had a hæmorrhage and the attending danger. She made a rapid recovery.

J. W. CANDEE: A lady, pregnant the second time and about three months gone, underwent a severe operation; the abdomen was opened and the adnexæ completely removed. There was pus in both sides of the pelvis, requiring a great deal of dissection—one of those blind, unsatisfactory situations that have to be worked out little by little as you go along. She was on the table two hours or more. Her family were told that she would of course abort. She made a good recovery, with one exception—suppuration of one of the glands of the neck. Since returning home she has been steadily and gradually improving in condition, and yesterday I received a telegram that she had been delivered of a male child and everything was in fine order!

REPORT

OF THE

BUREAU OF PÆDIATRICS.

"A Circumcision Shield," - - - - - JOHN L. MOFFAT.
"Tubercular Meningitis," - - - - - - F. W. HAMLIN.
"The Temporary Teeth," - - - - CHARLES G. PEASE.

A CIRCUMCISION SHIELD.

JOHN L. MOFFAT, M. D.
NEW YORK, (Brooklyn).

Although usually considered a minor operation, circumcision is really a surgical procedure entitled to and demanding all advantages that may be derived from the latest improvements in modern surgery —fundamental among these are asepsis and such protection as will ensure undisturbed healing.

In babies the great difficulty of applying and properly retaining in place any bandage after this operation has led me to discard all dressings but a powder—glucol, aristol, or any antiseptic powder which will be waterproof—and a cage or shield to prevent anything touching the wound.

For this a modified and enlarged vaccination shield has proven very satisfactory: A pliable ring, that may be moulded to fit the groins and include the scrotum, is well covered with a waterproof varnish which also coats the four interlacing stiff wires which arch high across it. The height at which these keep the clothing must be sufficient to leave the organ untouched when in erection.

Such a shield can readily be washed and sterilized. When fitted to the patient its ring is padded with aseptic absorbent cotten and it is held in place by a half inch strip of rubber adhesive plaster extending around into each gluteal fold, while a third runs upward on the abdomen. In place of this last a piece of sterilized tape may be pinned from the ring to the band or vest. If desirable, a pad of absorbent cotton in sterilized gauze may be so arranged over the shield as to catch the urine; the padding to the ring can be replaced with fresh cotton with but little trouble after each urination, if necessary. Fæces are not apt to invade the wound or soil the shield; the thigh straps should be sponged clean immediately after each stool.

With this shield on patients may be dressed and permitted to run about as soon as they have recovered from the effects of the anæsthetic.

When the shield is removed for cleansing or a dressing, be sure that the nurse is unremitting in her watchfulness lest the wound be touched by leg, hand or foot.

The condition of the wound may, by this apparatus be under constant observation, as the straps holding the shield in place do not extend over it, and any necessary treatment can be done either through the cage or upon tilting it partly off for the purpose.

The adhesive straps are not inconvenient to either patient or nurse; if the skin be very delicate their positions may be varied a little from time to time and the tender spots bathed with arnicated alcohol.

TUBERCULAR MENINGITIS.

F. W. HAMLIN, M. D.
NEW YORK.

Tubercular meningitis is a disease so fatal to life that it would seem at first sight to be useless to discuss its treatment. It is the consensus of opinion among those who have studied this disease that no well-marked case has ever recovered. However we know that tubercular disease in other parts of the body has been cured and its further progress stopped, and it seems to me an interesting and profitable subject of inquiry to consider the possibility of cure in cases of tubercular meningitis.

It has been my fortune, good or otherwise, to observe seven well-marked cases of this disease during the last ten years, and these seven cases, while all terminating in death, have presented such diverse symptoms in many respects that I believe a brief consideration of this interesting disease will not be wholly without value.

The first case that came under my observation was that of a beautiful little girl, aged two and one-half years, the child of wealthy parents, surrounded with every luxury and the object of painstaking care and attention. This child, reared on the bottle, had suffered during infancy from a mild form of Barlow's disease and malnutrition; but at the time when the tubercular disease began was apparently in perfect health. The disease pursued the classical course. The onset was extremely insidious and slow and she was treated for malaria for three weeks before she came under my care. The fever, while continuous, was not high, reaching about 101° F. in the evening and dropping to 99° F. in the morning. The appetite was fickle, and the sleep restless and disturbed with an occasional sharp cry while asleep. The child's disposition which was previously very cheerful and sunny became irritable and at times actually cross. Very gradually the fever

increased in intensity and the head symptoms became more pronounced. The appetite failed completely and emaciation was progressive. Finally a convulsion occurred followed by deep coma accompanied by the sharp, shrill cries so characteristic of the disease, and death resulted after an illness of six weeks.

In other cases the premonitory stage was of much shorter duration or was not so well observed. In three cases the first symptom of any import was a convulsion or a series of convulsions followed by coma and death within a week. One case was peculiar by reason of a urinary deposit which closely resembled the deposits of urates frequently seen in children. Chemical examination showed that these deposits consisted mainly of phosphates. This case presented the slow intermittent pulse which is regarded as characteristic of the disease. The "tache cerebrale" or the redness produced by drawing the finger over the skin and lasting for several minutes was obtained in five of the seven cases. In one case the convulsions were unusually severe and were followed by a temporary motor paralysis of one arm and one leg. This brief review of these cases will serve to call attention to some of the main features of this terrible disease and indicate to some extent the hopelessness of successful treatment after the tubercular process has become localized.

In the earlier days of homœopathy, physicians of our school claimed to cure this disease by the exhibition of such remedies as bell., apis., bry., hellebore and sulphur administered in the thirtieth potency. Tooker, in his work on "Diseases of Children," says, in this connection, "The consummate faith in the higher potencies held by the early leaders of our school excites our unbounded admiration. There is no question that their faith was well founded. What is the trouble now? Is it because the course of disease has changed or that infantile constitutions have become less responsive to our attenuated remedies, or have we lost to some extent the art of accurate prescribing? Certain it is that we do not in these degenerate days get the same results claimed by the early prescribers."

I shall not attempt to answer the questions which Dr. Tooker propounds, but my experience in treatment of tubercular meningitis coincides with his. I have completely failed in my attempts to cure in accordance with the principles laid down by the fathers of homœopathy.

Some years ago the late Dr. Miner of New York read a paper before the County Society upon the treatment of tubercular meningitis by means of iodoform used externally in the form of an ointment applied to the shaven scalp, and internally in the 3^{x} trituration. About the same time or a little earlier there appeared in the Hahnemannian Monthly an article upon the use of iodoform in meningitis. This article affirmed that the symptoms produced by iodoform in poisoning cases very closely resembled the symptoms of meningitis and asserted that iodoform ought to be a most promising remedy in the treatment of all forms of meningitis. Since that time I have used the iodoform treatment as advocated by Dr. Miner in all my cases of tubercular meningitis, but the result has been the same. All the cases have terminated fatally.

. I have given this subject considerable thought and have come to the conclusion that the only hope of successfully combatting this disease lies in the treatment of the child before the disease has become localized. Nearly all these cases give a history of malnutrition, rickets or hereditary predisposition to tuberculosis. These children should be under treatment and close inspection from the age of two to that of seven years. Their diet, exercise and sanitary surroundings should be carefully supervised. Such remedies as calc. phos., calc. iod., calc. carb., and sulph., according to indications, should be faithfully and intelligently administered for months and years. An occasional dose of tuberculinum after the method of Dr. Burnett is, I believe, exceedingly helpful. The use of proteinol after meals especially during the winter and spring months is a valuable adjuvant. Graduated cold baths with the addition of sea-salt are also to be recommended. In short, maintain the highest possible standard of health and vigor. In this way only do I believe that we shall succeed in curing our cases of tubercular meningitis.

DISCUSSION.

JOHN L. MOFFAT: I have cured tubercular meningitis; am as sure of the diagnosis as one can be without an autopsy. The principal remedy was iodoform. This is a great remedy for tuberculosis, especially the acute varieties. If Dr. Hamlin had tried the thirtieth and two hundredth potencies I believe he would not feel hopeless of success in this disease. Children respond well to these potencies. I have had them act well when the 3d or θ seemed to have no effect. So long as you are satisfied with your selection of a remedy do not abandon it without trying it in the two hundredth; your skepticism must not (in mere honesty) stand in the way of possible benefit to your patient. The two hundredth will usually let you know in twenty-four hours if it is going to do any good. Dr. Dearborn's rule should never be forgotten: "When satisfied with your prescription give larger and larger doses until you get either aggravation or relief."

W. H. PROCTOR: Bacillinum is sometimes used for tuberculosis.

THE TEMPORARY TEETH.

CHARLES G. PEASE, M. D., D. D. S.
NEW YORK.

The temporary teeth are too often looked upon as of little importance and unworthy of prophylactic and remedial thought and care; the little ones are allowed to suffer not only from the pains and aches of carious teeth but from the loss of the masticating power of the dental organs through their broken down condition or untimely loss,

and the masticating power is often impaired for life by mistaking the six-year molar for a temporary tooth and allowing it to suffer the same neglect and the same fate as the others. Masticating power is also often permanently impaired by irregularity of the permanent teeth, caused by the too early loss of the temporary teeth and the encroaching of the adjoining teeth upon the space caused by the loss, and the consequent crowding of the permanent teeth out of line when they erupt.

The non-absorption of the roots of the temporary teeth will also cause the permanent teeth to erupt outside the line of the arch.

Understanding as we do that caries is caused by the presence of an acid, either the acid of fermentation or of gastric conditions, or viscid fluids of the mouth due to unfavorable systemic conditions, being conscious of the fact that the dental surgeon does not always come in contact with the children, it should be the duty of the physician not only to instruct the mothers in the care of the children's teeth, but to urge upon them the importance of having frequent inspections made at the dental office.

The physician is with the child in illness, the time when the teeth are in the greatest jeopardy from viscid fluids of the mouth, fermentation, etc. How often does the physician examine the teeth or suggest a line of treatment for the protection of the dental organ at this or any other time? The physician should work hand in hand with the dentist and give all the required instructions, when by the nature of things the dentist does not come in contact with the child.

The child's mouth should be washed nightly with water of an antacid reaction by means of a camel's hair brush, and syringing. Floss silk should be used where spaces afford lodgment for food, and during illness the mouth should be syringed with a solution of bicarbonate of soda and water half drachm to the ounce three times a day, and always before sleeping at night. When syringing is impracticable the mouth and teeth may be swabbed with the solution.

I have in these few lines simply thrown out a hint to the general practitioner, but it is a most important one and means much for the welfare of the child.

DISCUSSION.

F. PARK LEWIS: I have had the pleasure of seeing some plates in the office of one of the most experienced dentists of New York, in which I was greatly impressed with the bad work that is done by the large number of dentists in pulling the temporary teeth. The writer of the paper rightly says that this is a matter that the family physician should have cognizance of. Failing to recognize the fact that the jaw changes as the child grows older, it is not at all an uncommon thing for a dentist to remove teeth, because the narrowness of the jaw crowds them. There is the very large, high-arched palate, accompanied by adenoids, in which you get a deformity of the face which will be a serious detriment to the girl later, the narrow-rat-like jaw.

Such cases can be relieved and the teeth given room by an intelligent, judicious dentist using arrangements to widen the jaw as the child grows.

G. G. SHELTON: Some fifteen years ago while attending a family of the Scotch race, I was surprised to find that the children had little trouble in teething and I was told by the mother that children in Scotland rarely had trouble in getting their teeth. They had brought with them some flour made of the Scotch oat. I found a Scotchman on Reed street, New York, who obtained this flour* for me, and from that day to this where I have been able to use it, putting a little of this flour in the baby's food, after it had reached an age that it was able to digest the starch, I have never had any trouble with their teeth.

JOHN L. MOFFAT: I suspect the American custom of eating so much sugar with oatmeal and possibly less of an outdoor life, have more to do with this immunity than any difference in the oats of the two countries or even of their milling.

BEMSLEY WILLIAMSON: A child cannot safely eat oats before its teeth are formed. Oats contain by analysis what would make good teeth, but the young baby cannot utilize this. We need potash, sawdust contains potash; ergo, eat sawdust. Horses fed on oats may have supernumerary, irregular or carious teeth.

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*"Midlothian Oats."

REPORT

OF THE

BUREAU OF SURGERY.

"Uterine Fibroids," - - - - - - W. LOUIS HARTMAN.
"The Scope of Posterior Colpotomy," - - - SHIRLEY R. SNOW.
"Gall Stones," - - - - - - - NEWTON M. COLLINS.

UTERINE FIBROIDS.

W. LOUIS HARTMAN, M. D.
SYRACUSE.

After listening to the very able paper presented to this society one year ago by our friend, Dr. Emerson of Boston on this subject, I feel that what I am about to say will not be very interesting, or rather that my paper will seem insignificant by the side of the one you listened to at that time. But there are so many things connected with fibroids that are not clearly brought out in our text books generally, and which are liable to be overlooked by the men who are not working with these subjects continually, and they are of so much importance that I feel that too much cannot be said regarding the same.

Most people have the idea that fibroids are of slow growth. To be sure they are in most cases, but there are exceptions and those exceptions are the points which I shall endeavor to bring out. The very nature of a fibroid would give us to understand that they were of slow growth, but there are cases where one can see where rapid growth might take place, and those I have found are in connection with pregnancy. This is brought about by the greater supply of blood being forced into the pelvic cavity during this period which produces a congested condition, if you please, and therefore the growth is better nourished during this time than it is otherwise, therefore the growth is more rapid. Of course, this class, or rather the class of fibroids that this would affect, would be the interstitial and the subserous, as in the submucus variety as we all know, pregnancy would be almost impossible. Should it occur, it would be of such short duration that the tumor would have very little opportunity to make any progress. Still it is surprising how rapidly some of them will grow during this period. To illustrate this fact I will cite a case which came under my observation in 1898.

Mrs. F., aged 29, came to me for some pelvic trouble. I found upon examination that there was a large growth extending from within the pelvic cavity nearly up to the umbilicus. The history rather led me to believe that she was pregnant of longer standing than she had any idea. She gave a history of three months' pregnancy but the mass was too large for such a time, and as I made the examination I found that if there was a pregnancy of longer standing, there was also a fibroid. Inquiring into the history carefully, four or five months prior to this she had been examined by a surgeon in Washington, D. C., who told her she had a small fibroid which did not amount to much. In fact she has only noticed this coming out of the pelvic cavity for about two months. When I removed the growth I found a three months' fœtus together with a fibroid which weighed nearly eight pounds.

Before I go farther I will speak of another peculiarity in connection with fibroids, and that is the popular idea that we always have excessive menstruation where fibroids exist, but this is conceded to occur in only fifty per cent. of all cases. In the subserous fibroids we are not liable to have excessive hæmorrhage and my experience has been that very often we find the interstitial variety will not always produce excessive menstruation, but in the submucous variety we always have the excessive flow. Now in the case of fibroids we have men who tell us if they are causing no trouble we had better let them alone, but let us see if this is conservative treatment and the right thing to do for our patient. Let us study for a moment the effect they have on the circulation. The heart and the generative organs seem to have a peculiar affinity for each other. When there exists a fibroid of the uterus in subjects that are a little inclined to be fleshy, we find fatty degeneration of the heart. In lean subjects we are liable to have dilatation of the heart, that is where the fibroids have existed for any length of time. Only recently I was called in consultation to see a case of fibroid where the patient was of a spare nature, and the history showed that from the time the patient had begun to suffer with a fibroid tumor there was noticed a dilatation of the heart. This was of such a marked degree that it had been deemed unsafe by two surgeons to administer an anæsthetic so as to perform an operation for relief of the same. This same condition I have noticed in other subjects but not so marked as in this one. I presume this is due to the fact that the trouble had not existed as long as in the patient that I saw but a few days since. As to fatty degeneration, I have noticed this in two or three cases recently. My attention was first called to this in a case where there existed some abnormal condition of the uterus for some time. The history was as follows:

Patient aged 33, rather of a stout build, had ceased menstruating about four months prior to my examination. Patient going on to this time thinking there was nothing but a simple pregnancy, but the growth was so rapid that it aroused her suspicions and led her to consult me regarding the same. I made an examination and diagnosed the case as pregnancy complicated with fibroid. Inquiring into the

history of the case I found that she had trouble with shortness of breath while exercising which led me to make an examination of the heart which revealed to me a fatty condition. This was another case where pregnancy had excited the abnormal growth. So there are two reasons why fibroids should be removed early or as soon as they are discovered. As we all know, if there is such a thing as preventing fatty degeneration of the heart, it is much easier to do that than to cure it after it is thoroughly established. This however is not the only reason. There are many others. In the first place if we have fibroids existing, the chances are against the patient ever becoming a mother, as we all know that a fibrous uterus is quite inclined to empty itself in the earlier stages of pregnancy. But it also prevents conception. Then again we are liable at any time to have an inflammatory condition arise causing adhesions, and if the time comes when we are forced to operate it makes the operation more formidable and places the patient's life in danger, and who is there who can tell when degenerative changes are liable to take place in any forms of morbid growths. Who can tell when the time will come when these tumors will become carcinomatous or sarcomatous involving the intestines and pelvic peritoneum and all other adjacent organs, and place the patient in that position where human hands are of no avail? Who is there who could ever forgive himself if knowingly he let a patient go on to the stage where surgery was of no avail and the patient filled an untimely grave through his negligence or conservatism? There is not a surgeon in this room who has not seen that same thing occur many times when the patient has been brought to him in an excessive inflammatory or malignant condition too far advanced for operative procedure. I do not think there is a surgeon in the room who will not bear me out when I say no tumor which can be recognized is too small to remove. Of course, I realize the fact that there are fibroids which never give any trouble or are sufficient to cause any discomfort to the patient. I also realize that in a series of autopsies that the uterus in fifty per cent. of all cases will contain fibroids.

DISCUSSION.

G. W. ROBERTS: The main proposition of the paper is the advocacy of early operation in cases of fibroid tumor, and I think it is eminently right. I could not go as far as the doctor, and say that every fibroid which can be recognized should be removed. His very quotation that 50 per cent. of autopsies in women show traces of fibroid tumor, rather leads us to be a little slow in operating cases which have not as yet, either by their size or peculiar location, given rise to symptoms of importance. True, we cannot tell when a fibroid is going to become sarcomatous, but I don't imagine that the proportion of sarcomatous degeneration in fibroid tumors is very great. If they give rise to peritonitis we have plenty of warning of it. The patient generally has a sharp attack of peritonitis and when that condition has begun it is time enough to operate, but no one is justified in doing this sort of an

operation unless he has a safe and certain technique. The dangers of the operation per se are not great, dependent largely on the size and location of the tumor; that being the case it would urge us to early operation. I do not know what operation the paper intends to advise, but as we are talking on this subject I wish to call attention to the fact that a very large proportion of these growths can be removed without sacrificing the uterus—not all of them, but myomectomy as distinguished from hysterectomy is an operation of great advantage and is one of growing importance. I believe that we should strive in every case where it is safe to remove the tumor and leave the uterus.

DR. HARTMAN: In answer to Dr. Roberts' question regarding what operation I might advise, I would not advise any particular operation; often when those fibroids are small, in their infancy, we can do a minor operation and relieve the patient of any further trouble, not allowing the growth to go on and sap the system year after year, finally requiring a major operation which would jeopardize the patient's life. One point that I had in mind when I said early operation was this: We find so many times that men inexperienced in the use of electricity when trying to reduce fibroids in that way cause firm, dense adhesions which make it almost impossible to remove the growth. I always advise my patients to have them removed, instead of using the electrical treatment. Many men do reduce tumors with electricity; yet in electrical treatment for fibroids they kill more than in operative procedures, and are only successful in two or three per cent. of cases. That is one reason I advise the operation early.

We have not had a discussion of the part I wished to bring out more particularly—the effect fibroids have on the heart. I have been observing this for two years now. First my attention was brought to it from a heart trouble with a history dating back to a beginning growth; since then I have been examining the hearts of all such patients and I have found ninety-five per cent. of them with dilatation or fatty degeneration.

THE SCOPE OF POSTERIOR COLPOTOMY.

SHIRLEY R. SNOW, M. D.

ROCHESTER.

The vaginal route for treating abnormal conditions in the pelvis has been in vogue long enough to determine by experience its sphere of usefulness. To be sure there is still a wide difference of opinion. The strong advocate of the method claims everything in sight and out of sight—chiefly the latter, while the adherent to the abdominal route narrows its scope to very limited confines. The former claims that

a scar upon the abdomen is not in keeping with the æsthetic sentiment of the times, while the latter can see no reason why the abdominal wall should be left untouched. Sentiment should play no part in the treatment of disorders of the pelvis. That great bugbear of former times, hernia, cannot with so much propriety enter into the discussion, inasmuch as with our improved method of closing the wound and with proper after care few hernia follow.

As regards ease in operating certainly the abdominal route must be given the preference, for here we are enabled not only to feel, but can use our eyesight and sense of smell if necessary. Through the vagina we must handle it at arms length, so to speak, while through the abdomen we have it at our finger tips. If we strike a hæmorrhage even the most expert vaginal operator must admit the difficulty with which it is controlled through the lower route even with the appliances for using the electric light in the vagina.

In considering the time required for recovery we must differentiate between the clean and unclean cases. In the former, when the vaginal wound can be closed and the patient allowed to get around in ten to twelve days, we must admit that this method has the advantage provided the ultimate results are equal; on the other hand, where necrotic tissue is present and drainage must be maintained the case will recover more quickly if we go through the abdomen, remove all the diseased tissue and convert it into a clean case.

It is claimed that the vaginal route is preferable for exploration and diagnostic purposes. Here one should remember the anatomy of the parts, how the ovary is supported by the broad ligament and two small ligaments, one running to the uterus and the other to the pelvis, how the Fallopian tube lies in the upper free border of the broad ligament. It should also be remembered that in a large majority of the diseased conditions we find this ligament stretched out and lax, allowing the ovary to become prolapsed. Taking these facts into consideration what must be the result when we open through the posterior cul-de-sac, pull these organs down into sight and then try to place them back. If prolapsus did not exist previous to operation the chances are greatly in favor of its existing afterwards, also the tendency must be to produce retroversion of the uterus. In support of this opinion allow me to cite the following case:

Mrs. R. H., age 24, was examined by me in September, 1897, to determine the question of pregnancy. At that time the pelvic organs were in a normal condition and position. I saw nothing more of the case until a year later, when she entered the hospital suffering from an abscess of the left tube. Six months previous she had submitted to an operation in another hospital at which time the right tube and ovary had been removed through the posterior cul-de-sac. She consented to an abdominal section and I removed the mass upon the left side. The old stump was found on the right side, the horn of the uterus being drawn down and held by the ligature used to tie off the broad ligament. This being freed the uterus assumed its normal position and remained there, the patient making a good recovery. Con-

trast this with the removal of the tube and ovary through the abdomen. As I write this paper a typical case comes under my care. The patient, 26 years old, mother of one child, upon examination shows a retroverted uterus, fundus sensitive. The right ovary slightly enlarged. My advice is ventral fixation. Under anæsthesia an incision one and one-half inches long is made. The right ovary is found full of small cysts; the left ovary in good condition. It is decided to remove the right ovary and tube. This being done we find the fundus of the uterus drawn up into a normal position and held there by the shortened ligament so that ventral fixation is unnecessary. If this had been removed through the vagina the fundus would have been bound back instead of forward by the operation.

It is my experience that any tumor which has a confining sac, including pus tubes, is better removed through the abdominal incision. The following case, more instructive than pleasant to watch, illustrates this point:

March 5th, 1899, I confined Mrs. W. with her first child. The labor was normal, except forceps had to be applied to help the head over the perineum. Everything went well to the ninth day, although the lochia changed to a creamy, inoffensive discharge on the third day. Upon the ninth day the patient had a chill followed by fever. The condition did not yield to intra-uterine douches of peroxide of hydrogen and a small mass could be felt upon the right side. The patient was taken to the hospital. An aspirating needle through the posterior cul-de-sac withdrew a creamy fluid. An incision was made and drainage established. The temperature dropped and the patient improved; one week later the temperature rose again and a mass developed in the right iliac region. This was opened an inch above Poupart's ligament and six ounces of a creamy fluid evacuated, beside a wad of hair. The patient improved, but pain developed in the umbilical region, the stomach became irritable and upon February 10th, I made an incision just below the umbilicus. The same creamy fluid was evacuated at this point. By this time the patient was about exhausted. Champagne was the only nourishment given for five days, when the patient rallied and continuing to do so, she was placed upon a proper diet. Again a tumor developed, this time in the left iliac region, but without a rise in temperature. The patient was allowed to walk around; suddenly, in the seventeenth week, she was taken with a chill followed by fever. Upon examination I found the tumor on the left side pointing in the posterior cul-de-sac; from this we evacuated a pint of serous fluid. The cavity closed down and the patient is now able to do her housework and take care of her baby, but had I removed the small tumor through an abdominal incision at the first operation the patient would have been saved much suffering and I would have escaped many an anxious hour.

Another set of cases to which I would refer are the true pelvic abscesses, forming outside of the Fallopian tubes. These are particularly liable to follow abortion and are surrounded only by the products of inflammation and not a true sac. The pus forms rapidly and large

quantities may be found in two or three days from the onset. A case that recently came under my care presented the appearance of a seven months' pregnancy three days after the initial chill. This was opened and drained through the cul-de-sac and a good recovery made. Care must be taken to break up the different pockets of the abscess at the same time not open into the abdominal cavity.

I shall not mention those cases in which the uterus is to be removed, for it is admitted that in an uncomplicated case, where the uterus is not too large, the vaginal route is perferred. In closing I would say that for exploration the abdominal route is preferable; that when the tumor is surrounded by a sac the abdominal method gives the best result; that in true pelvic abscess without a confining sac, the vaginal route gives the best chances of recovery.

DISCUSSION.

DR. LEE: I desire simply to state that during the past year, I have re-operated on four patients who had had colpotomy performed and in three of these cases the sigmoid flexure of the colon was found bound down by adhesions so as to cause partial obstruction of the bowels. In some cases portions of the ovaries and tubes were left behind and at the site of the abscess numerous adhesions were discovered, including the intestines, the bladder and the broad ligaments. This incomplete mode of operation had left all the patients invalids and I believe that every surgeon in the room can recall one or more cases in which colpotomy had been performed and afterwards the patient had found it necessary to have a second operation performed before she could be cured. This is a common thing. In the American Institute at Atlantic City this year my own paper brought out a discussion on colpotomy and every member of the section took exactly the position that these surgeons have taken to-day; they were unanimous in their condemnation of colpotomy except in a few well selected cases and they are unanimous in it here. You will remember that the late William Goodell in his early days tried to direct the practice of ovariotomy in this channel; he did remove a number of small cysts and diseased ovaries through the posterior cul-de-sac and then gave it up and the profession never approved of the method. It has been revived and if we would carefully go over the literature and compare notes—if we would attend the different societies and discuss the subject—the consensus of opinion would be that colpotomy has had its run. The practice is now to select a few cases especially adapted for the operation and confine it to those and do most of our abdominal and pelvic surgery as we always have done through the abdomen.

W. L. HARTMAN: I am glad to hear Dr. Lee make that assertion; I did not know but that I was the only man who had had that experience. After doing the vaginal route I have been obliged, in one case, to open the abdomen and liberate the band of adhesions which were tying down the sigmoid flexure so that we got almost obstruction. The same thing has occurred to me twice in the last year and that is just the reason I am a little bit shy in doing work through the vaginal route.

GALL STONES.

NEWTON M. COLLINS, M. D.
ROCHESTER.

"But gentlemen, he died." Such were the words one of the most eminent diagnosticians of our day was wont to use as he sent for the post-mortem remains to confirm his diagnosis, and I fear this can too often be said of our patients after operations upon the common bile duct for gall stones.

Descriptions of these operations with improved technique sound well on paper, but if the operation itself is simply successful and the patient dies, we have not yet reached the goal of our ambition. Can we not learn lessons in one field of surgery by our experience in another? For instance, not many years ago we used to attack nearly all pus collections in the pelvis through the abdomen with a mortality of about 25 per cent., now these are drained through the pelvis with scarcely one per cent. mortality. Are not the conditions similar? In neither case is the patient in good condition for a severe operation, such as an abdominal section or the removal of a stone from the common duct, but will stand drainage through the vagina or the gall bladder, and later the more serious operation, if necessary.

The anatomy of the parts may help us in arriving at the cause of death in some of these cases. The sub-hepatic space, the only one interfered with when operating upon the gall bladder, hepatic, or cystic ducts, is separated from the small intestine by the omentum as far down as the head of the cæcum, and to the left as far as the splenic flexure of the colon; it is easily drained and a hernia does not follow long drainage as it does lower down in the abdominal cavity. But when we attack the common duct we have to open the lesser peritoneal cavity where it is much more difficult to work and much harder to get good drainage. You will see from the drawing that the common duct passes over the portal vein and the vena cava, and at its juncture with the pancreatic duct under the duodenum the parts are abundantly supplied with lymphatics; just an ideal place for infection from pus germs and colon bacilli, which are almost certain to be present and escape when the common duct is opened to remove the stone, often exciting fatal peritonitis. The strain on these parts in getting them up high enough to operate necessarily bruises the tissues and helps make absorption more certain. Healthy bile would undoubtedly do no harm here, but when obstruction has taken place we are almost sure of a septic condition similar to that found about a ruptured appendix.

Case I. February 1st of this year I was called to see Mrs. M., aged sixty-four years. Family history good. She had been suffering at times, for a number of years, with pain in the right side of the

abdomen, high up, where she had noticed an enlargement. This time the pain was so intense that her physician had resorted to morphine, but without relief. Examination revealed a tumor so large that it caused obstruction of the bowels with much distension. The mass reached from the ribs down as far as McBurney's point and extended to the umbilicus. It was so hard and caused such grave symptoms that cancer was suspected, but as it was not nodular and had been there for some time with but recent growth, an enlarged gall bladder seemed more probable; however, a guarded prognosis was given and an immediate operation advised. The patient consented and in less than an hour she was sent to the Rochester Homœopathic Hospital, where an exploratory incision was made and an enormously distended gall bladder found filled with thick, black fluid and at the bottom, broken down gall stones presenting the appearance of coarse black powder and completely obstructing the cystic duct. After removing all that was possible and stitching the gall bladder to the peritoneum, the bile soon began to flow into the gall bladder, showing that there was no longer obstruction. The common duct was not interfered with and there was no jaundice, complete recovery ensued.

Case II. May 25th, 1899, Mrs. B., aged 50 years. She gave the following history: About a year before her nurse had found a bunch somewhat larger than an apple, just below the ribs on the right side, but as it was not painful she neglected to consult a physician until a month or two previous, when a surgeon examined her and called in a colleague to confirm his diagnosis of a tumor, probably of the intestine, which he said, if not already malignant would soon become so. An immediate operation was advised. As most of the patient's relatives live in Rochester, she came on for another examination and operation, if necessary. When she consulted me I found a fluctuating tumor, seemingly a distended gall bladder the size of a cocoanut, between the free border of the ribs and the umbilicus on the right side. A favorable prognosis was given and operation advised and reluctantly consented to since there had been very little pain. Incision showed the gall bladder contained a pint of clear, thick mucus, and at the bottom the stones contained in bottle number two. The cause of the trouble proved to be a complete obstruction of the cystic duct by stones, of which I was able to remove all but a few fragments. Some of these fragments passed on down and the remaining ones occluding the cystic duct caused a constant mucus discharge, very annoying to the patient. After trying olive oil, and equal parts of iodine and alcohol, without benefit, an anæsthetic was administered September 5th, and the opening of the fistula stretched so that the index finger and a pair of forceps could be introduced. The remaining fragments were found lying loosely in the cystic duct and were easily removed, after which the finger passed without difficulty into the common duct. The edges of the fistula were next freshened and silk worm gut sutures put in place ready to be tied as soon as bile began to flow. This took place on the following day and the wound was closed, union taking place by first intention. The patient's appetite improved and at present she is

perfectly well. It is rather remarkable that the stones in the cystic duct did not cause more pain.

Case III. I will give the history of this case as written by the patient's own physician. "Miss L. M. P., aged 50 years. About five or six years ago she began to experience discomfort in the region of the gall bladder and soon after noticed an enlargement there. During the succeeding years she was never free from a certain degree of distress, amounting at times to paroxysms of intense suffering. Never during this time was she jaundiced or constipated. She consulted physicians of skill and experience and the difficulty was variously diagnosed as floating kidney, hepatic cyst, and cancer of the stomach. In January, 1899, a pelvic trouble necessitated abdominal section and the surgeon in charge examined the gall bladder, "Distended, quite largely distended, but no call for surgical interference, as remedies will without doubt take care of it", said he. After recovering from the operation she was comparatively comfortable until last May, when the distress in the side became very much increased with complete loss of appetite and constipation, with some bloating of the abdomen, but no jaundice. This continued until June 28th when after the use of an enema, there was a copious discharge of pus from the bowels followed by a marked relief of suffering. She immediately went to the mountains hoping to gain strength, and for a time seemed to improve. Then the distress returned, with "the bloating of abdomen and a gradually developing jaundice. She was brought home July 21st and presented the following symptoms: an extreme degree of jaundice, almost to bronzing, great distension of the abdomen, extreme tenderness over the gall bladder which seemed enlarged to the size of the double fist, mental hebetude, complete suppression of urine, frequent liquid stools, and paroxysms of agony." July 21st at midnight Miss P. presented the condition as above described. On being told that her chances were scarcely one in one thousand, she begged to be given that one chance; her friends also wished it, so at 1 a. m. an exploratory incision was made. Upon opening the peritoneal cavity three or four gallons of serum came away and a very tense gall bladder presented itself; the cavity being walled off, the gall bladder was opened, at least a quart of thick, creamy pus flowed out and the large stone which you see, was removed.

Nothing further was done as in her poisoned condition she could not stand it. The paroxysms of pain ceased, but she continued to grow weaker until her death the following evening. Unfortunately no post-mortem was made.

Olive oil has been recommended in treatment of gall stones. The results do not warrant our losing valuable time in waiting for imaginary results. I have experimented with olive oil as a solvent for gall stones and it has no effect whatever, neither does alcohol, but ether and chloroform dissolve them very rapidly.

Dr. Walker has used ether successfully, injecting it through the gall bladder and cystic duct.

If I get a suitable case of obstruction in the common duct I certainly shall try it before attempting to open the duct.

I have hoped to impress upon you that simple cholecystotomy, or draining the gall bladder is not a dangerous operation and should not be postponed if you are reasonably sure of gall stone; that when the common duct is closed it will stop all absorption of bile until the duct is opened by surgical operation, or you succeed in moving the stone on by dissolving it with ether; that it is not best to operate on the common duct unless your patient is in good condition.

It has been proven that bile is not necessary in the economy and that it only aids the pancreatic juice a little in digesting fats and starch. It undoubtedly has some effect in preventing flatulence, but this can be overcome by using oxgall tablets.

DISCUSSION.

DEWITT G. WILCOX: I presume the object of discussing a paper is to find all the fault with it one can and say but little good of it. I don't like the statement which the writer makes, incidentally, that we have a mortality of twenty-five per cent. in making cæliotomy for pus tubes, because it is not a fact. They may have it in Rochester but here in the United States, we do not. From the statistics I can recall ten per cent. is high and five per cent. is more generally true.

As to the similarity of pus tubes and gall stones, I may not be a good judge; I never had either, but I cannot imagine anything more dissimilar. In one you have tubes filled with a substance, foreign and poisonous to the system (pus), which when effectually removed by any method, removes all further danger. In the other you have a mechanical condition, which by obstructing a duct, diverts the secretion of an organ into other channels.

I fail to see how, by opening the gall bladder and allowing the bile to run out externally, you are doing anything to remove the obstruction. To be sure, the patient is not being further poisoned by cholæmia but you have added an extra operation and when the second does come, it is just as difficult of performance and just as dangerous to the patient. Again there is this paramount objection to the method, namely, there may not be any gall bladder to drain. In two out of three cases which I have had recently there was such complete atrophy in the one and such dense adhesions in the second that it would have been quite as easy to have brought up the spinal column and sewed it to the integument, as to have brought up the gall bladder. I do agree with the writer, that when the gall bladder can be brought to the edge of the incision, it is a very simple operation to open that viscus and drain it or remove therefrom gall stones; and I further agree, that to open the common duct and remove therefrom a stone and close the opening is one of the most difficult operations the surgeon is called upon to perform for the reasons mentioned. If draining the gall bladder would relieve the conditions, it would be a most happy way out of the dilemma; but the relation of his third case seems to be a demonstration of its futility. There he had a complete obstruction of the common duct, as was evidenced by the jaundice, suppression of urine, paroxysms of pain, rapid debility. The gall bladder was

opened, one free stone removed, but that did not, in the least, aid in the relief of the obstructed common duct. I have no doubt a post mortem would have revealed a stone in the common duct.

Now there is wisdom in Dr. Collins' suggestion in draining the gall bladder if we apply it thus, namely, remove the stone before it becomes lodged in the common duct. How are we to know when there is a gall stone in the gall bladder? Here is the lesson we must learn from this subject: Every person who is subject to attacks of gall stone colic runs a great risk of common duct impaction, simply because there is likely to be a larger stone sometime, which will find lodgment and further impaction. In fact there are eighty chances in one hundred of this impaction occurring sometime. By opening the gall bladder and removing any accumulated stones, you not only remove these stones but the bladder by being stitched to the wall is put upon the stretch and is quite likely to atrophy and is thus prevented from forming more gall stones, for it is the secretion from the lining of the gall bladder which causes the stones to form. In fact, we don't need a gall bladder anyway any more than a horse does and he has none, and if we did not have any gall bladder we would have no gall stones.

Now there is another class of cases wherein one large gall stone has formed and remained in the gall bladder, which latter is greatly distended with pus or pus and bile. These patients do not have true gall stone colic but they forever complain of a constant discomfort under the liver, some sharp attacks of pain, occasional attacks of nausea and vomiting with chills and fever but no jaundice. They are, in ninety-nine cases out of a hundred, diagnosed as malaria or bilious attacks and may thus live for years and die of other troubles.

Now there is the third class wherein the gall stone is impacted in the cystic duct. There can be no jaundice as you can see, for the bile has a free exit to the intestines but we get more reflex irritation from this class than all others. The symptom here (I say symptom because there is scarcely more than one) is persistent, ever continued nausea and vomiting, such as you get in bowel obstruction, with a steady pain under the liver, bowels obstinately constipated and very likely an enlarged gall bladder but no jaundice. Your patient may die from this condition owing to the constant emesis.

Now we come to the fourth class and I claim it is possible to recognize all these stages of the gall stone by a close observance of symptoms, for I have seen them exhibited and verified by operation. In the first, second and third class, opening of the gall bladder will undoubtedly cure the patient and that at a slight risk, but not so the fourth. Here we have an obstructed common duct; the stone has succeeded in passing the sentinel at the entrance of the gall bladder, again at the outlet of the cystic duct into the common and has fled precipitately, as the novelist would say, through the common duct, but has been held up at the gate-way into the duodenum, because of a little sphincter muscle there situated. What is the result upon the patient? She has been conscious of this passage of the stone ever since it left the gall bladder. Stones in gall bladder do not, as a rule, give pain. She has complained of intense agony for days; not the dull discomfort of the

cystic obstructions, but, agony; more or less vomiting; morphine only will give relief. She has had gall stone colic before, but she will tell you this is different because it will not cease. After the stone is lodged at the extremity of the common duct, her attacks of pain are remittent. It may have been days in passing. Now she begins to look jaundiced, her stools are light in color; she has some temperature; each new attack of pain brings a chill. There is no distended gall bladder in all probability. She has days, possibly weeks, in which she has no pain. She even clears up of her jaundice, because the stone acts as a valve and floats away from the opening, because the circular muscles which hold the stone are tired out; but it is sure to come on again, the jaundice grows deeper, exhaustion is more marked, vomiting frequent and stools clay colored. Every new attack runs the temperature a little higher, reaching 104°. What is going to be the outcome? What can be the outcome when eight or ten ounces of so poisonous a substance as bile is forced into the general circulation every twenty-four hours? Inevitable death, and it is positively foreshadowed by the foregoing symptoms. Our patient may last from three to eight months in the condition described and every day nature is crying out piteously for relief. What can we do? Give sweet oil? Yes, by the quantity and it may do good but the chances are it will not; same of chelidonium and china. It is a mechanical condition and mechanical means must be employed to remove the difficulty. But let me say here, don't wait too long for oils or remedies, for the operation to be successful, must have the support of a fair amount of strength and cholæmia depletes the patient rapidly. Is it not worth while to know positively the symptoms indicating the action of gall stones in the various localities and thus anticipate a condition dangerous in the extreme?

DR. COLLINS: I do not see how Dr. Wilcox can say that opening the gall bladder and the cystic duct does not take away the danger. He admits that the danger of that operation is very very slight. Later, if necessary, you can do an operation on the common duct and remove the stone or crush it and cause it to pass on down. It certainly takes away the symptoms of absorption, because the bile gets free exit. The operation is often done by uniting the gall-bladder to the Murphy button; the bile flows on through as it does when it goes through the common duct. As regards the similarity between pelvic abscess or appendicitis and this, I do not think the doctor understands me. I meant when there is a stone in the common duct, there are evidently germs around this stone. You cannot open that common duct without stretching and bruising the tissues and just opening up a bed for absorption; certainly drainage will stop the absorption of the bile until you can work further on. The statistics I had reference to as to pelvic abscess were more like cellulitis, where you tried to open up the abscess in the abdominal cavity. I had reference to pus collections in the tissues.

REPORT

OF THE

BUREAU OF NEUROLOGY.

"Remedies Reliable in Mental and Nervous Diseases," WILLIAM MORRIS BUTLER.
"Suggestions for Change in the Lunacy Laws," - JOHN T. GREENLEAF.
"The Opium Habit," - - - - - AMOS J. GIVENS.
"False Beliefs," - - - - ARTHUR PALEN POWELSON.
"Chorea," - - - - - - - JAMES PURCELL.

REMEDIES RELIABLE IN MENTAL AND NERVOUS DISEASES.

WILLIAM MORRIS BUTLER, A. M., M. D.
BROOKLYN, NEW YORK CITY.

When one first glances at the homœopathic materia medica it seems like a tractless wilderness of words. Each remedy appears as a composite photograph of all the ills of mankind. It is no wonder that the memorizing and classifying of several hundred of these heterogeneous collections of symptoms should seem to the student an impossibility. Nor would the work prove so difficult if all the symptoms were reliable; but there is such a collection of utterly worthless dross that years are required to separate it from the gold. If each one was obliged to labor alone the task would surely prove hopeless. The only way in which the work of elimination can be successfully accomplished is for each one to do his part. In this spirit we present to this society the mental and nervous symptoms of a few drugs which by many verifications, we have learned to regard as perfectly reliable and certain.

Aconite.—The mental characteristic of all aconite cases is fear.

Whatever the form of the disease, whether mania, delirium tremens or neurasthenia, when the prevailing state is fear aconite will almost invariably help. A form of fear which we have frequently encountered in delirium tremens is that of being shot. Upon entering the room the patient will crouch and shout, "Doctor, look out, they will shoot you from over the door." In numbers of such cases aconite has given prompt and permanent relief. In neurasthenia fear of riding on a

railroad train, on a trolley car, or going over the Brooklyn bridge, is a common symptom and readily disappears under the influence of aconite. Aconite has also proven our mainstay in acute neuritis. Nor is this to be wondered at, as the provings of aconite give an almost perfect picture of the pains of neuritis.

Anacardium.—There is no remedy more useful in the treatment of chronic mental disease than anacardium. What aconite, belladonna, hyoscyamus and stramonium are to acute mania, anacardium is to chronic mania and the first stages of dementia. Loss of memory and profuse profanity are the predominating characteristics. If you have never heard an anacardium patient swear you have much to learn. He will make the eyes of a fish-wife open with wonder, when he turns on his flood gates of "cuss words." In these cases anacardium works wonders. It must, however, be persistently given for months to get its full effect. We have usually had the best results in these cases from the 30th or 200th potencies.

Arnica.—No other remedy, in the homœopathic materia medica, is as efficacious in cases of cerebral hæmorrhage, or embolism, as arnica. Under this remedy numerous cases of motor aphasia with paralysis of the right side of the body have been completely restored. The power of this remedy in dissipating clots is wonderful. In brain troubles we always use the remedy in the 30th potency. In speaking of arnica we would also remind you of the danger of too strong external applications of this drug. Several severe cases of erysipelas and numerous crops of boils have come under our observation when undiluted tincture of arnica had been applied to the skin. Given in the 30th arnica is an almost certain cure when boils appear in successive crops.

Argentum nitricum.—While not as rich in mental symptoms as some of our drugs argentum nitricum has one hallucination of sight that is characteristic, viz., the patient sees snakes everywhere. My attention was first called to this symptom many years ago. A patient suffering from acute melancholia was brought to the Middletown Hospital for the Insane and for weeks suffered untold agonies from the delusion that snakes were all around him and all over him. I have seen the perspiration roll off from him in streams through his efforts to escape from these snakes. Argent. nit.^{cc} promptly and permanently removed this delusion and restored the man to perfect health. In nervous dyspepsia characterized by the formation of enormous quantities of gas, apparently independently of anything eaten, argent. nit. has proven in many cases of incalculable value. Threatened tabes and congestion of the posterior columns of the cord with imperfect coördination are also frequently helped by this drug.

Arsenicum.—The numerous mental symptoms recorded by the provers of arsenicum would naturally suggest its usefulness in melancholia. Many years of successful trial have taught us to prescribe arsenic with confidence in the worst cases of melancholia where the depression is a reflex of the lowered physical condition. In mania and delirium tremens, when the patient sees vermin and bugs crawling about him and is continually trying to brush them away,

we have often cleared up the delusion and cured the patient with arsenicum. Arsenicum is also frequently curative in neuritis, when the disease is characterized by severe burning pains and great restlessness.

Agaricus muscarius.—For chronic twitchings of the muscles of the eyes no remedy can compare with agaricus. In numerous cases of chorea with this peculiarity we have administered this drug, and invariably with prompt and satisfactory results. It has an especial affinity for excessive tea drinkers.

Baptisia tinctoria.—In severe cases of melancholia with stupor attended by a very high fever, rapid pulse, heavily coated tongue, hurried respiration and complete stupor the effect of baptisia is simply miraculous. We have seen many of these cases when apparently hopeless speedily restored to health of body and mind. In none of these cases has the disease ever returned.

Bromium.—Bromium has a characteristic delusion that strange persons are looking over the patient's shoulders and that she would see some one if she should turn. When this delusion occurs, either in any form of insanity or in delirium tremens, bromium will do you good service.

Calcarea carbonica.—Calcarea carbonica is another remedy in which fear is the prevailing mental condition. When the constitutional symptoms are present with fear, calcarea will help the patient whether positively insane or only suffering from neurasthenia.

Cantharis.—Cantharis has a characteristic symptom of barking like a dog and trying to bite when anyone approaches. This is a very rare symptom but we have met with it both in mania and delirium tremens, and in every case cantharis has cured the patient.

Chamomilla.—Chamomilla is credited in its provings with hallucinations of hearing, but although we have given it a fair trial in many such cases, it has never succeeded in removing this hallucination. This is always one of the most obstinate symptoms of mental disease and when markedly prominent makes the prognosis decidedly doubtful.

China.—When a mental or nervous disease has been produced by a draining of life fluids, loss of blood, too long nursing, or excessive seminal losses, there is no remedy to be compared with china. We have seen cases, apparently beyond all hope, completely restored by china.

Cimicifuga.—Cimicifuga is another valuable delirium tremens remedy. After a debauch, when sleeplessness is caused by processions of rats, and all sorts of strange appearances about the bed, do not forget to give cimicifuga, as it has achieved a lasting reputation in this class of cases.

Cocculus.—Cocculus is a valuable remedy in attacks of vertigo, caused by diseased arteries of the brain.

Digitalis.—In cases of depression with marked slowness of the pulse we seen digitalis make prompt and permanent cures.

Gelsemium.—In cases of neurasthenia marked by brain fag and a tired, dull ache at the base of the brain, gelsemium has no rival. In

almost countless cases we have removed the apathetic condition of the mind and restored the physical vigor of the patient by a persevering application of gelsemium. Gelsemium has one symptom, often present in neurasthenia, viz., an impulse to throw one's self down when looking over a height.

Hyoscyamus.—Fear of poison is a characteristic delusion of hyoscyamus, and this drug has removed it in multitudes of cases of insanity. Hyoscyamus is very often demanded in mania. The hyoscyamus case of mania is perfectly depicted in Shakespeare's Ophelia. When indicated no remedy is more often curative in insanity. Hyoscyamus is also frequently indicated in the sleeplessness of delirium tremens when accompanied by much muscular twitching.

Lachesis.—Lachesis is useful in cases of insanity when the patient is exceedingly loquacious. These patients talk incessantly and so rapidly that it is almost impossible to understand them.

Lilium tigrinum.—Lilium tigrinum is curative in cases of neurasthenia possessed by the idea that they are going to be crazy, and where the nervous condition is a reflex of ovarian and uterine disorders.

Natrum muriaticum.—Natrum muriaticum will cure melancholia when the patient constantly pours out floods of tears and has an old look much beyond her years. Patient is worse in the morning, weak and emaciated, and often has been subjected to malarial influences.

Petroleum.—One of the reliable symptoms of petroleum is the delusion that another person lies in his bed beside him. I have promptly cured delirium tremens characterized by this delusion with petroleum^{cc}.

Phosphorus.—Phosphorus has a variety of delusions. The delusion of faces peering out wherever the patient turns his eyes, and leering at him from all the corners of the room, is marked in its recorded provings. In many cases both of insanity and tremens characterized by this delusion I have prescribed phosphorus and I do not recall a case in which it failed to remove the delusion. Phosphorus has also proved curative in many cases of neurasthenia and brain fag and helpful in the early stages of tabes.

Stramonium.—Stramonium has a multitude of mental and nervous symptoms and we should naturally expect it to be exceedingly efficacious in mental and nervous diseases. The mental diseases in which it has proven curative have been characterized by the intensest violence. The mania drives the patient into a perfect frenzy. Delusions of the most frightful character, night and day, terrify the victims. Whether suffering from mania or delirium tremens the fury of the patient knows no bounds, and can only be restrained by physical or mechanical force. Whatever the particular form of the delusion it is always of a frightful character. In these terrible cases stramonium has proven a sheet anchor.

Tarentula hispania.—In the worst forms of Sydenham's chorea there is no remedy to compare with tarentula hispania. The more general the involvement of the muscles, the more marked the incoördination and the greater the helplessness and apparent hopelessness of the victim, the more effective is this drug. In many of these formid-

able cases have we produced speedy and permanent cures with this drug alone. The potencies which we have found most efficacious have been the 12th, 30th and 200th.

Zincum metallicum.—One symptom produced by zincum metallicum we wish especially to emphasize, and that is an excessively tender spine. Too frequently this condition is encountered in neurasthenia and often proves very obstinate. In such cases zincum has proved more often curative than any other drug.

DISCUSSION.

JOHN L. MOFFAT: An old lady of about seventy suffering for two years with a second attack of melancholia recovered under anacardium. There was no disposition to swear but there was some religious apprehension and marked irresolution. I gave anac. because she was better after eating.

PRESIDENT SHELDON: I want to speak of the use of hyoscyamus in a patient suffering from melancholia; the symptoms were being suspicious of her friends, and afraid of being poisoned. I was called to see the lady who had been ill for a year; she would not take food from any of her friends because she was afraid they were going to poison her to get her property. The attending physician told me he had given her almost every remedy that could be given, both homœopathic and allopathic. I made the suggestion that if he look in Allen's Materia Medica under hyoscyamus he would find her symptoms. He prescribed hyoscyamus[30] and cured the patient.

SILAS S. SIMMONS: This paper deserves a great deal of credit and of attention. Do not let such papers drop.

F. PARK LEWIS: I was very much interested in the paper of Dr. Butler. I only wish to supplement it by one remedy which, in my judgment, has been of value in melancholia—the correction of refractive errors in those suffering in this way. A case came under my observation not long since; a young man who twice spent periods of five months in the State Hospital and seemed to be again threatened with a like condition when I found him suffering from a very high degree of astigmia which had been uncorrected. After having corrected it, the depression disappeared; that was several years ago and from then until now there has been no return of it. I have since that time seen a number of other cases that lead me to believe that the strain, the constant irritation which the nervous system suffers from by the endeavor of the eyes to do work for which they are unsuited, must in time so lower the nerve resources that one form or another of nervous disturbance results. That certain forms do result and that they are relieved by the correction of this strain I have now no doubt whatever. I simply speak of melancholia as being one of the conditions about which I have no certain knowledge, because I have not yet seen a sufficient number of cases relieved under the application of the

proper lenses, but I feel sure that the first essential, whether it is the curative agent or not, should be the relief of all refractive strain.

DR. MOFFAT: Dr. Lewis has given us a very important suggestion, and one that possibly may explain some of our failures in homœopathy. For instance, Dr. Butler tells us that hyoscyamus was one of the certainties in medicine when the patient expected to be poisoned. I have failed with hyoscyamus in that condition. I recollect distinctly a patient having that symptom very marked and hyoscyamus tincture or 200th failed to relieve it. I do not know why; I would not presume to say, but sometime we may be able to find out why. The doctor says that gelsemium is indicated when the patient has a tendency to throw himself down from a height and that gelsemium has cured it. The probabilities are that some of us will go home and have some such patient and will give him gelsemium—in any dose, in any potency—maybe with success, maybe with temporary palliation and maybe failure, but he or she will be cured by operation for heterophoria. Cutting the muscles of the eyes will cure that symptom, probably by relieving nerve strain due to lack of balance of the extrinsic eye muscles. Here is an instance where it would be better for us to find out the pathological condition of the symptom underlying the indications for the remedy.

Dr. BUTLER: I would like to say with reference to Dr. Lewis that I agree entirely with him as to the correction of any trouble in the eye. I never have a case of neurasthenia or mental trouble that I do not examine it thoroughly and if there are any indications of eye strain I have these corrected before I begin treatment. I had a very interesting case about two years ago, a patient with a perfect hemianopsia. I studied that case up and found that it was due to mental worry. Gelsemium was indicated; I gave her that and sent her to Dr. Moffat, who applied galvanism through the eyes to the nape of the neck. It was a case which was incurable—according to the old-school books—the result of a lesion in the brain; but she made a nice recovery. I agree with Dr. Lewis entirely that while there is a reflex of any kind, whether trouble in the rectum or eye or wherever it may be, it must be removed before we can expect any result from remedies.

SUGGESTIONS FOR CHANGE IN THE LUNACY LAWS.

J. T. GREENLEAF, M. D.
OWEGO.

An examination of the statutes of the various states of the Union will promptly reveal the fact that hardly any two agree as to the course to be pursued in caring for the person and property of a lunatic.

In the digests of the lunacy statutes of forty-four States, it has been found that in thirteen States a jury is required to pass upon the mental

condition of the alleged lunatic. In two States the appointment of a jury is discretional with the judge, in eight it is discretional with the lunatic or his friends. The number of men composing a jury may be anywhere from six to twenty-four, although eighteen is the favorite number. In three States commissioners are appointed for each case by the judge before whom the complaint is made. In one State two justices of the peace are required for a decision, in one State three justices, in four States a probate judge must give his opinion.

In fourteen States the opinion of one physician must be obtained, either as an expert or as a member of the jury. In nine States two physicians must join to pass upon the condition of the alleged lunatic.

In eight States only is there a regular and permanent Commission in Lunacy, who take charge of matters of this kind. In one State the friends and relatives of the patient are considered competent to commit him. In about half of the number the presence of the alleged lunatic in court is required; in about one-third it may be dispensed with at the option of the judge.

All the States provide for the care of indigent lunatics at public expense, but in only six is there any provision for the licensing and inspection of private institutions for the care and custody of the insane.

In hardly any State is there any provision for the recognition of the jurisdiction of any State, other than the one in which the process is instituted, in matters of this kind. A lunatic who may have escaped from the custody of legal authority of any one State cannot be returned thereto without going through the process of commitment as prescribed in the State where he is found. A citizen of any State, who may be adjudged insane in any State other than his own, because of his conduct and condition as evinced when temporarily sojourning in that other State, must be re-committed on his return home.

From time immemorial a lunatic has been thought to be morally responsible for his condition, if not for his acts. He has been classified with criminals and treated accordingly, though often much worse, imprisoned, loaded with chains, beaten, intimidated, starved, subjected to the rigors of winter without proper clothing and warmth, confined in unsanitary buildings, and in filth and misery too horrible to be thought of, his case has been a sad one. Later on the shadow of the old belief and classification still kept its baleful cloud over the minds of legislators, for while they honestly sought to preserve the "right to life, liberty and the pursuit of happiness," belonging to the alleged lunatic, they still treated him as a criminal. To them it seemed that the great danger to be avoided in legislation on this subject, was the unjust incarceration of an alleged lunatic. In fiction, such an error in judgment and morals is often depicted, but the facts are that only a very few cases of illegal commitment of insane persons have ever been known.

The danger of too early a release of a properly committed insane person, or of the return to society of one who was simply passing through a clear interval, and in whom a dangerous homicidal impulse was likely to appear at any moment, never seemed to have been a

matter of thought by these gentlemen of wisdom who were appointed to frame our laws.

If the present view of insanity—that is, that it is a disease and one that is not yet fully understood, even by experts—the mistake of allowing a justice of the peace, or a jury of the ordinary type, or even the general practitioner of medicine, to decide in any given case, is too obvious to need argument in this paper.

With all the foregoing statements in view, it seems to the writer that some steps should be taken, first to unify the lunacy laws in the United States, second to put the matter of commitment and of release from custody under the control of those whose judgment is least likely to err.

As a possible solution of the two problems above stated, the following is offered—a convenient number of experts in insanity should be appointed by the Governor of each State, and this appointment confirmed by the Senate. Specific and definite requisites for eligibility to such a position should be prescribed by statute, among which should be at least ten years intimate and close experience with the insane. These experts should be paid by the State. They should have entire charge of the commitment of all cases of insanity, and control of all committed cases cared for outside of the regularly chartered and inspected institutions. To avoid any chance of error in commitment, each case so committed should be visited three times in the first three months of his or her incarceration, either by the expert committing, or by one located near the institution in which he or she is detained. They should also have charge of the release of all cases from an institution when a cure has been accomplished.

Their report of a given case, either verbal or written, should take the place of all other testimony on this point in a process for the appointment of a committee of the person or property of a lunatic.

There should be some arrangement for the acceptance of the commitment obtained in one State by all other States of the Union. The number of these experts should be sufficient, and they should be so located in the State as to make their services easily and promptly attainable, when required.

All cases of so-called insane criminals should be under their jurisdiction.

Beyond the powers and jurisdiction, as above stated, and the necessary details for the working of this system, the present arrangements for the State care of the insane should not be interfered with in any State.

DISCUSSION.

J. W. LESEUR: We should approach with caution the wholesale changing of any existing law. It will be found, I think, by careful study that the legislation in this state particularly—and what is true of this state is true of other states—has reached its present status largely as the result of the experience of those persons who have had

to do with the classes affected by present laws. While it is undoubtedly true that unification of legislation as a general proposition is greatly to be desired; and while it is undoubtedly true, as Dr. Greenleaf has ably suggested, that something like a unification of legislation along the lines of treatment and of admission, of persons supposed to be lunatics to institutions provided for their care; it is also true that legislation should only be undertaken after most careful examination and consideration of the needs of the lunatics themselves, of the rights of those who are sometimes unjustly classed as lunatics, and after a very careful examination concerning the definition of what is termed "lunacy." There is a story that an old physician being called on to examine a supposed lunatic said, in the course of his examination, "You are a little out sometimes, ain't you?" And the lunatic replied with shrewdness, "Well, Doctor, we are all out a little sometimes." Recognizing the fact that there are conditions that closely simulate lunacy and still are not lunacy, it is unquestionably desirable that thorough investigation, research and careful study along these lines be undertaken. So far I agree that experience gives the writer an exceptional right to speak on this question and his especial work gives him a knowledge which is not possessed by most of us on this subject, but when he goes so far as to recommend that there be named by any authority, men who shall have as one qualification for office "ten years of experience," men who shall have sole charge of the examination and admission of supposed lunatics, men who shall have exclusive right in this question which the constitution and laws provide shall be only given to a jury composed of the peers of the person being examined or tried, there he makes a claim which the circumstances do not justify and the American citizens have no right to expect will be allowed. I believe that the average practitioner who knows the family history of the individual charged with lunacy, who has cared more or less for generations of the family under consideration—supposing him to have average intelligence and careful training, such as is required to make a physician in the State of New York—I believe his knowledge of facts in the case and his careful examination and his sense of justice and right and fairness toward the individual charged, is as likely, other things being equal, to secure justice as an examination by an individual coming sixty miles and spending a half hour or an hour hearing some expert testimony and consigning him to a prison. I believe that we are not ready yet, as a body—at least I am not—to recommend any change so sweeping. There are questions along this line of the care of lunatics that do deserve consideration and I believe one of them is that the power of the present Lunacy Commission in the State of New York is vastly greater than it ought to be. I believe that the tendency towards centralization in the affairs of medical societies, of medical interests, is one which every intelligent physician should regard with appreciation and consideration, and if, when we have considered this matter and talked it over thoroughly and fully, and have all come to something like a majority vote as to what is the best and wisest thing to do, I think then it is perfectly right, proper

and just to go to your representatives and say: "Gentlemen, there are certain things we desire and we believe we are entitled to them and there are certain things that we demand," and if our word is not listened to deferentially, then to say there are certain things that, by the grace of God we will have!

W. M. BUTLER: This discussion is all useless, for there is no practical danger of our changing the lunacy laws, but it seems to me that we have as much red tape in this state now as we can stand; I had a little illustration of that last summer. I do not believe in sending people to lunatic asylums if they are not insane, and I do not believe that there has been one person sent to a lunatic asylum in the last forty years who was not insane. I presume they may not be as strict in the country as they are in Greater New York, but here is a sample of the red tape. The law says that before a person shall be committed, the notice must be served upon him twenty-four hours before stating that an application for his commitment to an asylum is to be made. I had a patient who could not eat. She was as wild as a patient could be; she had three nurses with her and I had a straight-jacket on her and she was tied to the bed; the three nurses and the whole family had all they could do to control her. I went down to the judge with the certificates of two physicians made out according to the law, but he said: "You will have to go back and serve this notice on the patient." I said, "That patient cannot read." He said: "That makes no difference; that is the law." I went back and the patient had to lie there tied in bed for twenty-four hours longer before I could send her to an institution.

SHIRLEY R. SNOW: I think the law reads that it is possible for the judge to put patient into the asylum without waiting for the twenty-four-hour notice. He can waive that right, if he takes it into his mind to do so. I know that I had four years' experience in Rochester as city physician and had to examine the larger part of the insane patients. I think the best remedy for the trouble would be to provide a place of detention maintained by the State. A physician now, in a place like Rochester, if he has a poor patient and is not able to place her anywhere, and her surroundings are poor, must keep her in her house unattended for twenty-four hours, unless he can get the judge to waive the right of notice. If the State would provide such a place of detention where a suspected insane patient could be detained and examined and committed properly I think it would overcome a great deal of trouble.

D. H. ARTHUR: In the seventy-five direct commitments that we have had at the Gowanda State Hospital since February 25th there has been no instance where a notice has been served on a patient; it is left to the discretion of the judge.

DR. BUTLER: A couple of old-school doctors in Kings County sent a dentist to one of these institutions without going through with this form. The man was not so insane but that he knew they had broken the law; he threatened to prosecute the judges for this violation of the letter of the law and there is not a judge in our county who would dare to commit a patient upon whom a notice has not been served.

DR. GREENLEAF: I do feel that the common jury is not fit to pass on a man's sanity. I do feel that two physicians who are thoroughly well-read are not always sure whether a man should be sent out of an asylum or not, and I am still satisfied that the majority of judges do not know whether a man should be dismissed or not. There is another thing that should be cared for and this is the unification of the laws in the United States. If a man is committed in Pennsylvania, he has to be re-committed in another State, and vice versa. As my friend says, there is a great deal of red tape in this State.

DR. BUTLER: It seems to me that instead of appointing a Board of Medical Examiners to examine all the lunatics, it would be better for each medical college to have a good course in lunacy so that every medical student should know how to diagnose insanity, and to have the law students provided with a course on lunacy, as physicians are with a course on medical jurisprudence. I think that that would be a better way to increase the knowledge of the physicians, lawyers and judges than to establish another board of allopathic physicians.

DR. ARTHUR: I think it a good plan to have places of detention in the cities where the insane could be temporarily taken care of till properly committed.

DR. GREENLEAF: There are four in the Western States.

THE OPIUM HABIT.

AMOS J. GIVENS, M. D.
STAMFORD, CONN.

Opium and its history dates from the third century before Christ. Its chemical composition and medicinal uses are well known, consequently I shall not enter into detail concerning them but shall describe the dangerous and dreadful habit instead.

Opium addiction is a disease of modern times, found in all classes of society, and the great increase is enough to startle any one.

In 1767 the East India Co. first shipped gum opium to China, where the consumption soon became enormous; its use became so great and caused so much misery and poverty that the government tried to check it by legislation. In 1840 the Emperor ordered all the opium destroyed, but in 1860 it was again re-admitted and its sale legalized.

Forty years ago the opium habit commenced developing in the United States, and in 1843 the hypodermatic method of using it was discovered. In Eastern countries the favorite method is smoking, but in the United States it is usually taken by the mouth or syringe.

In 1870, 158,000 pounds of opium was imported into this country; in 1880, 343,000 pounds, and in 1890 one-half a million pounds, or

250 tons, one-half of which it is estimated was used in medicine. In the United States it is estimated that 100,000 people are addicted to its use.

In referring to opium addiction we include all its preparations, as their effects are practically the same when taken for a length of time. The sulphate of morphia, however, is most frequently used.

Of 235 cases analyzed by a Chicago physician

Morphine was used in	120
Tincture of opium in	30
McMunn's elixir in	2
Paregoric in	5
Gum opium in	50
Dover powder in	1
Unknown	27

Sixty-six were males and 169 females.

The tremendous business pressure and strife and the bustle and worry of our modern times are increasing this class of cases.

The opium habit and its consequences are well described in the writings of DeQuincy, Fitzhugh Ludlow and Coleridge; in fact DeQuincy's first book, "Confessions of an Opium Eater," excited the interest and curiosity of the laity.

Among professional men many doctors are victims. Of fifty cases cited by Erlenmeyer sixteen were doctors. Of 110 noted by Livinstein thirty-five were doctors, and of 300 cases 124 were doctors.

The effects of opium vary somewhat, according to the temperament, and are also influenced by the powers of imagination, methods of thought, etc. The poet experiences different sensations from the dull plodding laborer, and the effects are different upon the imaginative races of the East than on the dull Anglo-Saxons.

The Symptoms.—There is always a greater impairment of the appetite when opium is taken by the mouth than hypodermatically. Catarrhal inflammation of the stomach and small intestines is observed; there is partial occlusion of the bile ducts and different degrees of jaundice result. The bowels become constipated, which often in the advanced stages alternates with diarrhœa.

The skin generally presents a pale cadaveric appearance, due to the poor action of the liver; the functions of the sebaceous glands are lessened and the skin becomes dry and brittle. There is often hyperæsthesia with great sensitiveness to cold. The eyelids and face become puffy and swollen from dropsical effusion.

Upon the sexual organs the desire at first is increased in both sexes; but this almost universally gives way to impotence and sterility as the habit progresses. The menses in women become irregular and finally cease altogether.

The urea in the urine is lessened and uric acid increases; albumin and sometimes sugar are present, but disappear when the habit is broken. Morphine is found in the urine, and Livinstein says if it is found six or eight days after its use is supposed to be stopped the patient is using it clandestinely.

The circulation is often disturbed, there being headache, flushing of the face, flashes of heat and in some advanced cases a form of intermittent fever with chills. If abscesses intervene their appearance may be first indicated by fever and some constitutional disturbance.

Sometimes a hypodermatic injection may enter a vein; this irritates the vasomotor system and congestion of the head and lungs may be produced. There is often tremor on writing. The knee jerk is influenced. If absent we have to suspect tabes dorsalis; if increased we think of neuritis and spastic paralysis.

The mind is generally affected, but not to the degree of insanity, for that seldom results directly from the habit. There is a weakness of the will and perversion of the morals; loss of memory and morbid impulses of various kinds. There is also a disposition to be untruthful about the drug.

The size of the dose of the drug is sometimes remarkable. Ordinarily the medicinal dose of the drug is one-quarter of a grain, but DeQuincy, it is said, took 1,000 drops of laudanum a day. Several patients have come under my observation who have taken a bottle of morphine containing sixty grains a day, and one woman took twelve ounces of laudanum daily.

Of late the treatment of the opium habit has received the attention that it deserves. The vice theory should be eliminated; the case should be regarded as a distinct disease, a neurosis.

It must be borne in mind that there is no specific, each patient should be treated in a scientific manner based on rational principles. The temperament and constitution of the individual must be considered, and care must be used in assisting the patient in completely regaining health.

There are substitutes, but substitution does not cure, in fact there are many nostrums which are advertised and which contain nothing but disguised solutions of morphine.

Dr. Samuel Abbott, health officer of Massachusetts, in his official report for 1886, says: "Of twenty samples of so-called opium cures which have been obtained, all but one contained morphine."

In the treatment of opium cases the most important thing is for the patient to voluntarily place himself under the supervision and observation of a physician in a sanitarium where such patients are treated; but never under the care of a doctor who has taken the drug himself. It is useless to attempt to carry out any line of treatment in the patient's own home or anywhere but where the physician can direct and control the patient, for very few persons have sufficient will power to carry out any plan of treatment unaided. Co-operation on the part of the patient is desired. Patients of long standing have weakened will powers, and sometimes find it difficult to give earnest and intelligent support.

There are three distinct methods of treatment.

(1) Abrupt withdrawal—The Livinstein method.
(2) Rapid reduction—The Erlenmeyer method.
(3) Gradual reduction—Leahr Burkhardt method.

With the Livinstein method the patient is at once deprived of morphine. This plan is unscientific and barbarous, and attended with too much danger. If you go to Germany to-day you will see the famous hospital of Livinstein. The patient is admitted for treatment; perhaps voluntarily places himself under the conditions of relief. He is put in a padded room; the walls are carefully protected; every particle of furniture is taken out and a strong trained attendant is placed there with him; there he is kept and there he must suffer.

The patient gets nervous and restless, he stretches and yawns; he has coryza and sneezing. The intestinal tract, which has been partly paralyzed, is forced into profuse and sudden secretion and a profuse diarrhœa results. The greatest danger is of collapse and paralysis of the heart. Livinstein says that collapse may occur without any warning, without vomiting or diarrhœa, and when we least expect it. There is great danger; this trifling with a human life ought not to be.

Tuke says, "there is a certain organic change in the cell structure of the nervous system when narcotics are continued for any length of time, and these centers cease to act healthily or satisfactorily without the drug. The patient has been months or years developing a condition of the nervous system that is purely pathological.

Not infrequently despondency, mental indecision and even mania are the results of too rapid reduction. It has been wisely said that "the tyrant opium is bad enough without the tyrant physician to minister to its enthralled subject."

(2) The rapid reduction plan. This consists in withdrawing the drug in from eight days to two weeks; keeping the patient in bed well attended by experienced nurses and chemically restrained by bromides. Patients are almost unconscious from the effects of the bromides, which stupefy and deaden sensation. The danger of collapse is not as great as with the Livinstein method. I have not used these two methods, as they cause too much suffering on the part of the patient, and are followed with a train of nervous symptoms as a rule which is not desirable.

(3) The gradual reduction plan. This is the most scientific, humane and rational, and is the approved method in this country. It is the one utilized in my practice and adopted by every patient who tries to break the habit himself, and is the one DeQuincy resorted to with success. The daily doses are gradually and progressively lessened. It is best that the patient give up the syringe and administer the drug by mouth as soon as it can be done and the amount should not be known to the patient. The rapidity of reduction depends upon the effects witnessed upon the patient.

Whenever the doctor detects a too marked nervousness, neuralgia, or gastro-intestinal disturbances attendant upon a too rapid reduction, he must stop the reduction and permit the patient to become accustomed to the lessened amount. As the quantity becomes less the reduction should be more gradual.

It is often desirable that the patient should be tapered off on to some other hypnotic such as codeine or sulfonal or trional, thus avoid-

ing shock with a delicate nervous system. Bromides are contra-indicated in all anæmic persons.

Patients are nearly always debilitated, and a nourishing diet builds up the nerve centers and restores the blood corpuscles which are always impoverished. The nutrition of the brain and nerve cells should be attended to. Sustaining nourishment should be regularly administered and hot milk is of special advantage. Eggs and broths are allowed freely when borne well. Hot baths as hot as they can be borne are good. Hot salt baths with friction to the skin are of great value. With strong patients the cold douche along the spine may be beneficial but there is danger of too great shock in weak and delicate persons.

Stimulants should be avoided or very cautiously prescribed. Opium and alcohol are both stimulants and it is impossible to substitute one for the other without aggravating the condition we seek to relieve.

For the nausea, champagne is beneficial. Galvanism, especially in the neuralgia of the last stage of treatment, may be of value. A spray of ether, or massage, or bathing with alcohol, may alleviate the muscular aches and pains.

Among the medicines used are the old well known remedies avena sativa, cannabis indica, digitalis, arsenicum, nux vomica, hyoscyamus, humulus lup., belladonna, gelsemium, passiflora incarnata, phosphorus and caffein.

DISCUSSION.

C. A. POTTER: For one, I am very much interested in this paper on the opium habit, and appreciate the privilege of listening to an article by a writer of nearly fifteen years' experience in the treatment of morphinism. As Dr. Givens states, it is only for a short time that proper attention has been given to this subject, and now that we recognize in these cases a disease with an underlying disturbance of the nervous system they should be studied as any other pathological condition, and a scientific method of treatment followed.

The system of antidoting often leaves a patient with as difficult a condition from which to recover as the original opium poisoning. There is no one having had any experience in these cases who will disagree with Dr. Givens on the subject of where a patient should remain while under treatment: a reliable hospital with a physician having absolute control over the patient is the only place in which to expect success. Even when they come voluntarily and you have their entire support in the treatment, they have not the will power or nerve force sufficient to hold out under an abnormal temptation for the drug, unless it is impossible to procure it. These cases need constant care, the most nourishing diet, easily assimilated and directed towards restoration of the blood. Special attention should be given to the bowels; rest in bed is absolutely essential, and until the patient is well on towards recovery; then they should be allowed recreation in the open air.

My experience has differed somewhat from Dr. Givens' in regard to medication, having been connected with state institutions only; but I have seen good results with homœopathic prescription of the ipecacuanha in these cases. It is not a new prescription, having been used by Dr. N. Emmons Paine and the physicians at the Westboro Homœopathic Hospital, also by the physicians at the Middletown State Homœopathic Hospital.

The cases which have come under my observation have been treated by the abrupt withdrawal method, and with no bad results from collapse. It is possible with certain patients, and under certain conditions it might be advisable to modify this method to a rapid reduction. The same line of treatment could be carried out.

As homœopaths, I believe we should make an effort to find a similimum in these conditions, and in the pathogenesis of this remedy we are nearest to nature's law, I do not claim that ipecac is a specific or a substitute, but that it is a drug most closely allied to the poisonings of opium.

Evans, of Chicago, found, under careful study of opium, a mental condition of anxiety and fear of death; an extreme itching of the skin, due to dryness and inactivity of the glands. In advanced cases of opium poisoning we have the livid, bloated face; the patient yawns, stretches, convulsions, opisthotonos, sudden prostration, coughing and sneezing, with disturbance of respiration; the pulse becomes soft and weak. These symptoms we also find under the provings of ipecac.

My experience has not been so extended that I can say ipecac will prevent all cases of paralysis or collapse, but I think it will do all that any drug will do. In Hull's Jahr, you will find ipecac as one of the remedies for chronic abuse of opium.

The following case was discharged from the State Hospital at Gowanda only last Saturday, and may prove interesting: The patient was received July 27th, 1899. Male; 47; single; occupation, salesman. No history of insanity. Father died of heart disease, mother of pneumonia. Both parents had been temperate. This was his first treatment for morphinism; he attended a whiskey cure in Pennsylvania four years ago, received no benefit from the treatment, has not been as strong but more nervous since the treatment. On admission he was fairly well nourished; right hand partially paralyzed, anæsthesia of the thumb the past two months, pulse 96, soft, mitral murmur of the heart. He was nervous, had not been sleeping well for some time, realized the nature of his commitment and had a dread of the treatment he would receive. Ran away from his friends the night before to prevent being taken to the hospital. Admits having used six to eleven one-eighth grain morphia tablets by the mouth daily for the past two years, usually took the drug at night. It is probable that a greater amount had been taken. Drank whiskey since twenty-five years of age; periodical sprees; has been drinking heavily of late; has had no position for the past five years. Smoked fifteen or twenty cigarettes a day for the last ten years. Anxious to recover from the liquor and drug habit, but fearful of the treatment. Put to bed in the

hospital ward, to be given an enema of glycerine and aqua fervens; hot milk frequently during the night; ipecac. θ, 30 drops in half glass of water, teaspoonful every two hours.

July 28th. Put in a good night; slept fairly well between hours of medicine. Is looking better than yesterday. Tongue a little more clear; ate a good breakfast; no nausea, but bowels loose. Remedy continued during the day.

July 29th. Doing well in every way; tongue nearly clear from coating; pulse 72. Slept well. Slight tendency to vomit. Took four glasses of hot milk during the night. Teasing to go home to-morrow as he is sure he is cured of his drug habit.

August 1st. Doing well. Prescription changed to ipecac 2x, two hours.

August 9th. Eating and sleeping well. Remedy continued every two hours.

September 16th. Continued to improve. Has been assisting in light work for the past four weeks. Was taken home by brother to-day.

This case yielded to treatment much more readily than the majority. He suffered little and gained steadily from the time he was put on the remedy.

Another case whose condition was very low, will illustrate what the treatment will do where one would expect a collapse. Male; 67 years old; poorly nourished and so feeble he was scarcely able to walk alone. Gave the history of having taken one to two grains of morphine by mouth every three hours for six years, has had very little appetite for the past year. Claims he has not had a normal movement of the bowels for five years. A bottle of morphine found in his pocket was taken from him under protest; claimed he would die unless allowed the usual amount.

Put to bed; bowels evacuated by enema; given ipecac θ in half glass of water, two teaspoonfuls every hour. Remedy continued during the night; patient sleeping fairly well between the hours. In the morning said he was rested and refused morphine. Took some light diet. Remedy continued during the day and following night; patient took nourishment without nausea. Thirty-eight hours after beginning the remedy, patient was very sick, vomited freely. Prescription was then changed to ipecac 1x, hourly. Slept much of the time the following twenty-four hours, awaking occasionally, complaining of feeling very sick; would vomit but soon go to sleep again. Bowels extremely loose, stool a grass green. Continued in this condition until the morning of the fourth day, when the nausea began to lessen, bowels not as active. Temperature 100.8°, pulse 57, respiration 25. Took light liquid diet at intervals of two hours. Vomited three times during the day. Ipecac was discontinued, strychnia phos. 2x every two hours prescribed. After the fourth day he steadily improved, and two months after treatment began he was an entirely different man, had gained thirty-five pounds, was well and strong, with no desire for opium.

If the treatment is successful with these cases often requiring the most active medication, why should it not prove as effective in the

hands of the general practitioner, who usually has the patient long before he is turned over to the State care, which, as a rule, finds him without physical, mental or moral ambition, and in no wise capable of giving aid in a curative process.

W. M. BUTLER: I believe that curing the opium habit is very much like curing original sin—just about the time you have it cured it begins again. I have been through all these drugs mentioned. You cannot tell whether an opium-eater is cured unless you have him right straight in front of you. He will take that opium behind your back, swear that he has not taken a bit and you cannot detect it.

In the first place, if you cure him of one he is liable to substitute another drug. I had a man who was sent from Tennessee. He started out as a drinker, had delirium tremens and became a chloral eater. They put him on morphine and next he became a morphine eater and drank whiskey and chloral; then they put him on cocaine. When he came to me he would get drunk, eat morphine, and take chloral and cocaine.

I know of another case that was tried for murder in Brooklyn. He is now in Sing Sing. A drug clerk, he smoked cigarettes most of the time, took chloral part of the time and morphine; and he took nitro-glycerin and phenacetin. He had been cured of morphine several times.

JOHN L. MOFFAT: This ipecac treatment is very interesting. I wish the staff of the Gowanda State Hospital, after accumulating a number of cases treated as Dr. Potter tells us, would try smaller doses and increasingly higher potencies, and let us know their comparative results. These are the primary symptoms of ipecac, its stage of depression; are they better treated by material doses, by low or by high potencies? I should expect increased depression and a slower recovery from large doses than from the higher potencies. The potencies, even the 200th, act satisfactorily in other diseases, why not here? Is it desirable to cause a diarrhœa? The glycerine and water enema would be apt to cause that.

J. T. O'CONNOR: I agree with Dr. Butler in his pessimistic views as to curing the eater of morphine, and I think you might as well expect to cure original sin. Yet I know of one case that I can say was cured. It was in my early practice in Washington in the late 60's or early 70's. A patient was left deserted on the operating table —it was a perineal stricture. They made an awful blunder and he was left there to die. But he didn't die; he came under my care in an allopathic hospital and I was allowed to go to see him, although I was known to be a homœopath. That man had a two-ounce phial on the little table at the side of his bed. His arms were pitted with the marks of the syringe from using that stuff, and he wanted to get over the morphine habit more than anything else. He was a man of indomitable will. He was honest. I said: "If you do as I say, I will get you out of it. I will let that phial stay there, but if you promise when you feel the need of that phial to take one of these powders you will be out of it. I will give you powders of opium 200. Now, perhaps his will did it alone; perhaps the opium in the 200th potency was sufficient to

quiet the craving for the drug. Whether this was so I do not know, but that man got well, not of his surgical butchery, but he was able to get about and that man in two or three years was earning a good deal of money as a lobbyist in Washington.

Within a couple of years we have had at the dispensary of the College in New York a case of a man who came to me voluntarily asking what I could do. He had tried cures and had gone through all sorts of experiences in his effort to throw off the chains of this slavery and I tried the same thing on him. He was not in a hospital, but was going about exposed to dangers, as when a man is a little tired and some one will ask him to take a drink; I do not think he was honest, but he finally declared to me that he was reducing the amount of morphine to less than one-eighth. I gave him the same treatment—morphine 30th in this case—and whenever he had a craving for that he was to take a powder. Like most of the dispensary patients, he finally disappeared without my finding out the result. I think the isopathic principle should be pushed in these cases.

DR. MOFFAT: I would like to ask Dr. Potter if he has given it in the 30th or 200?

DR. POTTER: I believe potencies are better after you have the opium out of the system. I have been unable to get good results from the 30th where you have a system full of drugs, as you do in opium poisoning. That is the reason I believe you have to use ipecac in the tincture and use a lot of it, but as soon as you find the patient is beginning to sleep well, is able to take nourishment and is in a condition not to ask for opium, then I believe you should go on with potencies—second and third centesimal—and use these potencies until you find some other homœopathic prescription that will better fit the case.

D. H. ARTHUR: The opium patient will stand probably more ipecac than any other class of patients and I believe that is shown in the treatment by ipecac; but I believe, Dr. Butler, that you can't cure a patient addicted to the habit of opium. Dr. Potter's treatment will restore a case to a good physical condition, but after a man has been addicted to the use of opium for years the finer nerve-cells of the brain are organically impaired and I do not believe any treatment is ever going to rejuvenate them; you cas restore him partly to his former mental attainment, but never to what he was as a whole. I have seen whiskey fiends cured, that is, they have stayed well—free from liquor—for years, but I have never seen in my experience with opium a man who, after following it for two or three years has not gone back to it again. You cannot promise anything, but restore an opium fiend to a good physical condition and he will go back to it the first trouble he has.

DR. BUTLER: I believe ten years from now Dr. Potter will be as pessimistic as I am; fifteen years ago I had as good cures; I knew just how to cure all these cases, but they didn't stay cured.

DR. POTTER: A case is brought to the hospital unable to do anything but take opium. We can, with ipecac, put him in a good physical condition and able to work.

FALSE BELIEFS.

ARTHUR PALEN POWELSON, M. D.
Assistant Physician, Middletown State Homœopathic Hospital.

Wrong conclusions and false beliefs are not always traceable to a disordered mind. Individuals who enjoy normal mental health often assent to propositions and assertions which have no foundation in fact. The wise and the foolish will meet upon the same plane and fraternize over the same distorted views. It was Lord Bacon who said that superstitious prophecies are not only the belief of fools, but the talk sometimes of wise men. In the discussion of false beliefs it is difficult to determine where to begin or where to end; frequently the line which separates the false from the true is dim and uncertain. The light of one age becomes eclipsed by the more brilliant illumination of its successor. What was false yesterday is true to-day.

Archimedes said, give me a place upon which to stand and I will move the world; that place may yet be found, which Archimedes never saw, and by it the world of thought may be lifted into a higher and clearer atmosphere, free from murky clouds of doubt which have befogged the human intellect since the birth of man. Until that hour arrives there will be the same conflict of opinion, the same uncertainty, the same struggle after truth which has challenged the attention and inspired the hope and faith of the good in every age. If it be true that the sane have false beliefs, in what respect do they differ from the insane? Do we not all have ideas and impulses like unto those of the lunatic, and yet is it not possible to see and discuss in what respect they differ?

The delusions which may be termed sane are, for the most part, the offspring of ignorance and prejudice; such people never see beyond the limited horizon of their narrow environments; and yet, as if to prove the rule, we find men of the highest culture and attainments who as firmly believe in the existence of that which is not, as do the most untutored and unlearned. There is a class of phenomena, common to all, called by some sensory delusions. For example: the bent appearance of a stick placed in water; the double object seen through a prism; the moving of trees upon the landscape to one riding on a fast train; the mirage of the desert; the belief that an amputated foot is in pain, and that only one point of an æthesiometer is touching the body when in reality both are in contact. These are not, strictly speaking, delusions, but rather false perceptions due to a limitation of the power of the sensory organs.

We call a false belief a sane one when it is originated and developed by a train of thought completely at variance with the intelligent consensus of opinion of the masses and which, at the same time, is not easily and satisfactorily disproved.

In childhood we find the (sane) belief in Santa Claus and of the existence of a man in the moon, a pretty and pardonable deception which disappears with the mental development of the child. Recently an ophthalmologist has made the startling assertion that all cases of insanity are caused by insufficiency of the ocular muscles; there is a possibility that science and investigation may justify such an apparently rash statement. In that case, it must be admitted that all physicians now disagreeing with him, were laboring under a false belief.

Our great and immortal Hahnemann was considered by the learned people of Europe, living during his time, to be suffering from a delusion when he declared that the law of similars pointed out the only scientific way to cope with disease; yet, to-day, thousands of physicians and men and women in every walk of life attest to the sanity of Hahnemann's belief and the correctness of his conclusions.

The belief of Christian Scientists, with the tomb of Harold Frederic commemorating their faith, and the lack of belief of the atheists are striking examples of a deluded people in this enlightened age. Among the ignorant and credulous, epidemics of sane delusions frequently occur. History gives us many instances where thousands of people were simultaneously affected. In the year 1000 vast numbers of men in all the European countries, especially France, refused to till the soil or make any preparation for the future because they believed the world was coming to an end. An army of nearly 100,000 crusaders, most of them children headed and commanded by a child, set out, in 1211, to capture the Holy Land in the face of a long, fatiguing journey and against a force of well-armed and disciplined troops. The result is well known. They never reached their destination; numbers died by the wayside from starvation and exhaustion, others were killed and the remainder sold in slavery. Another example of an ignorant delusion occurred in Constantinople a number of years ago, when a large number of Mohammedans ran out from their houses yelling and discharging firearms during an eclipse of the moon, seeking thereby to frighten a bear, which, according to their belief, was devouring that satellite.

Not far removed from the borderland of insanity lies a condition known as eccentricity. Most eccentric people have a strain of insanity coursing in their veins which may have been directly transmitted from parent to child or indirectly through predisposition, insanity having had its origin in members of the same stock further removed. Not all of this class are peculiarly talented, for the insane diathesis is just as liable to produce foolish eccentricities or madness as it does recognized genius. Dryden says:

> "Great wits are sure to madness near allied,
> And thin partitions do their bounds divide."

A person develops eccentric habits by a process of deduction arrived at through reasoning in an illogical way, or he may acquire them through imitation.

The transition from eccentricity into insanity, although often occurring, is not appreciable. The majority of individuals presenting orig-

inalities, peculiarites and oddities, while not actually reaching insanity, are closely allied to it; as long as they do not injure themselves or others they cannot be called insane. What might be considered an eccentric act in one person might be proclaimed an evidence of insanity in another; therefore the nativity, religious and social surroundings, opportunities for education and the time in which an individual lived should be taken into consideration before we decide as to whether his actions are simply oddities of character or symptoms of a disordered intellect. Peculiar actions of an individual of a low strata of society might be considered by those in a higher one eccentricities, yet, if presented by a member of the more elevated class, they would be judged inconsistent with his education and social training, therefore a symptom of insanity. A boy may grow up with harsh and cruel treatment and afterwards hold himself aloof from his fellow men because his early training prejudiced him against them—this would be called eccentricity; but if, later, through worry, suspicion and apprehension, be believed he was being persecuted by certain individuals and resented it by irrational acts he would have overstepped the boundary into paranoia. An eccentric man is honest in his convictions and persistent in carrying out his projects and peculiarities. He is thoroughly convinced that he is right in his hobbies and cares little for public criticism or ridicule. He differs from the monomaniac in that his actions and beliefs are dominant to his will.

Insane delusions develop as a result of a perversion or weakening of the reasoning faculties. Through disease, fright, shock, over-worry or intense excitement, the reasoning and logical powers may become so impaired that the mind is capable of receiving faulty impressions. The person afflicted may at first entertain false ideas, yet believe them untrue and unreasonable and be able to banish them from his thoughts, but with gradual weakening of the will, the inhibitory processes are less able to repel the intrusion of these hostile invaders who continually reappear until they finally become fixed. No one can foretell what class of delusions any one individual will develop. A man of morbid disposition and unpleasant surroundings is likely to develop melancholia, with its depressive beliefs; another, through predisposition, mania, with its expansive delusions, while the life of a third has fitted him for general paresis, with its ideas of grandeur.

Hallucinations and illusions often cause delusions, and, in other cases, strengthen the beliefs already formed previous to their development. Lest some members of the State Society be not familiar with the distinction between delusions, illusions and hallucinations, it may not be out of place here to briefly differentiate them. A delusion is a false belief. An illusion is a mistaken perception, i. e., a perception of an object present, but in a different form from that in which it actually exists. Hallucination is a false perception, i. e., the perception of an object which, in reality, does not exist. For example: If I really believe I am the Kaiser of Germany, I am suffering from a delusion, but if I see a tramp and recognize him as the Emperor of Germany, I am laboring under an illusion; still again, if I believe I see the King of Prussia when no one is present, I have an hallucination.

To the hypochondriacal, illusions are especially important as an aid in confirming their morbid beliefs. For example: A patient who believes she is pregnant, shows as evidence an abdomen distended with flatus or impacted feces. Another claims she is thoroughly rotten and is undergoing decomposition; she tries to prove it by saying that the odor of her perspiration is that of decayed animal matter. A good illustration of an hallucination as a cause of a delusion is that of the French heroine, Joan of Arc. Joan was an ignorant peasant girl religiously and devoutly inclined. At the time her menstrual periods should have occurred (it is believed, on good authority, that she never menstruated) she was subject to nervous disturbances and cerebral irritation, accompanied by hallucinations of sight and hearing. One day, while standing in her father's garden, she heard a voice say: "Joan, you must prepare yourself for wonderful things; for Providence has reserved you to deliver France and restore to King Charles his lawful possessions." At first she did not pay much attention to this hallucination and made no preparation toward carrying out such a project. The voices, however, continued to come to her, from time to time, and, through their urgings and reassurances, she became imbued with the belief that only through her France would be saved. She at last determined to seek aid for her enterprise, and, after having gained an audience with the Duke of Lorraine and being examined by the dignitaries of the church and men of learning, she was put at the head of an army. This delusion was an insane one; she confessed on her trial that she had visions when she talked with St. Margaret and St. Catharine and was guided by their counsel.

The varieties of delusions that the human mind can produce are inconceivable. They are generally classified as genuine and spurious. The genuine, as the name implies, is created by the individual himself, while the spurious is purely imitative, acquired by association. Genuine delusions are divided into the systematized and the unsystematized. Systematized delusions are reasoned out, the patients being able to give reasons for their belief, but faultily associated. They are either expansive or depressive in character and are found in delusional insanity with exaltation, erotomania, paranoia and hypochondriacal melancholia. In the unsystematized no reason for a belief can be given; the emotional state is so intense that the will has no control over the reasoning and logical faculties. These delusions are also of an expansive and depressive type and are observed in the acute insanities and organic dementias. There is also a mingled form (the expansive and depressive together) found in confusional insanity, senile dementia, epileptic and pubescent insanities.

Patients who have unsystematized delusions believe that they have committed unpardonable sins; are the cause of the deaths of many people; the destruction of the "Maine", the Hispano-American war, etc., but, being questioned, cannot tell why.

A patient who has built up his delusions systematically cannot be argued out of them, while, on the other hand, the patient with the unsystematized can; especially is this true of paretics, who are easily

led away from their insane beliefs and immediately assume others, suggested by the conversation. To show the train of pseudological thought and the systematized manner in which delusions arise and grow, I cite the following case:

Case No. 3866—Admitted May 6, 1893; male; white; single; nativity, United States; age, 27. Initial history states that patient has never been considered mentally strong; has always been an excessive masturbator. A few years ago was thrown from a horse, near his home in Wyoming and sustained an injury to his head; since then has been gradually failing in both mental and physical strength. About one year ago became very suspicious and developed delusions of persecution; thought people were putting poison in his food which acted on his genital organs, producing emissions and greatly weakening him. Later, as these delusions progressed, he thought a number of people were following him about with the intent to murder him by poison. He became so apprehensive that he ran away from home, and after a year reached New York city, whence he was committed to the Middletown State Homœopathic Hospital. On admission was in a very weakened condition and said that poison administered to him by various people all over the country was the cause of his illness. Is very nervous; tongue pale and tremulous; hands blue and cold; pulse 80 and irregular; weight, 129 pounds. July, 1893, very suspicious and apprehensive. Asks that poison be not put in his food because it gives him headache and coated tongue in the morning. Is sure he is being poisoned and not a delusion. September, delusions are becoming fixed; he believes the doctors and nurses are poisoning him and asks that he be put under the care of other physicians as he is becoming weaker.

October, still suspicious; says he is sure he has a cancer of the stomach, due to poison. Is weaker physically; delusions unchanged, but more pronounced; masturbating.

January, 1895, abusive and threatening violence to those he believes are poisoning him. July, more suspicious, refuses food, won't take medicine. Holds out his hands to show how nervous he is; is sure it is due to the drug. Made an attack on patient because he thought he was talking about him. Is more irritable, abusive and profane. Says he can see a cross from his window on the mountain top, which signifies he is under the protection of God, and will be able in the end to triumph over his enemies. November, has been watching position of flies about the register the instant he awakens in the morning, and has diagnosed their various positions with the intention of having revealed to him the position of a medicinal plant that would prevent conception and in this way advance human happiness and prosperity. He says the first morning he noticed these flies he dotted down on a piece of paper their positions and connected them by a line. The outline suggested the form of a leaf to him, the plant of which would prevent conception. But how he was to find the plant was his next thought. The next morning the flies arranged themselves in a different way, the outline of which resembled the contour of Siberia. He then knew it would be found in that country. The next question

was how to get to Siberia, and again the flies helped him out by arranging themselves in the form of a boot—he was to walk there. He is now waiting for his release to make the journey.

1896, more irritable and suspicious, threatening those about him. Delusions remain fixed.

August, 1899, there has been no especial change in his condition for the past three years. His delusions of persecution are still present and firmly fixed, which make him homicidal and a source of care and anxiety to those who care for him. An analysis of this case shows, in the first place, that the weakened physical condition and tendency to suspicion of the patient was caused by onanism and an injury to the head. As the will power became impaired he was unable to reason out logically the cause of his debility. It did not occur to him that the seminal emissions were due to excessive masturbation, and on looking around for a cause his disordered mind suggested poison. This belief of poisoning was strengthened every day by different subjective symptoms constantly arising; the result of a developing hypochondriasis. After having satisfied himself that he was being poisoned, the next thing was to discover who administered it, and the idea that a conspiracy was formed by his enemies arose. He became frightened, and in a perfectly natural way tried to get away from them and wandered to New York City. After leaving his foes, he experienced the same symptoms that he did previously and became very suspicious of every one. When food was given to him he could tell by the looks and actions of the people who gave it that poison had been administered; at last he imagined that every one he met was trying to drug him. After admission to this hospital his delusions grew systematically and became more fixed. At first he believed the cook put poison in his food, then the attendants, then the doctors, and gave as proof his headaches, trembling hands and coated tongue. Being very irritable, suspicious and apprehensive, he refused his food and became so fearful that he tried to preserve his life by threatening to injure and striking those he thought responsible for his weakened condition. So throughout his whole case, and also the story of the flies, can be seen a methodical reasoning, but only pseudo-logical in character. At the present time he does not exhibit any other line of persecutory delusions save those of poisoning, which are firmly fixed. He is able and ready at all times to prove he is suffering from drug poisoning.

Many other very interesting cases could be cited, but this will suffice.

To determine what errors of belief are so pronounced as to have crossed the line between sanity and insanity, is one of the most delicate problems that can be submitted to human judgment, and the exercise of the judgment most responsible; a penetrable film may separate them, and it becomes difficult to determine on which side lies the truth and on which side error.

Insanity is, to a great extent, a "terra incognita" for our exploration. We have as yet trodden on its verge. The ample field, broad as the human soul, spreads before us. Carefully, studiously, experimentally, must we wend our way amid its intricacies; and when we

shall come to be able successfully to "minister to minds diseased", we shall have advanced our art far into the realm of the unknown.

An intellect dethroned is insensible to the processes of logic. To re-habilitate such minds and set them on their thrones again, to reign supreme over all their thoughts, will be indeed a crowning glory that awaits the future of our profession.

CHOREA.

JAMES PURCELL, M. D.
EASTON, PA.

The subject of chorea is one in which all physicians are more or less interested, and is usually looked upon as a self limited and less important disease to treat, yet it forms over one-fifth of the nervous diseases of children. There is very little of an original nature that I am able to report, but have had some experience in treating the more obstinate or chronic forms of the disease. The term chorea is derived from the Greek, the word signifying a dance. It appears to be a functional neurosis, characterized by irregular muscular contractions appearing and disappearing in rapid succession.

The disease as a rule appears between the ages of five to fifteen years, seldom before. Is infrequent in adults and quite rare in old age. Is more frequent in girls than in boys, in the proportion of one to three. The majority of the cases occurring after fifteen to twenty-five are in women. The climate plays but little part as a causative factor, as the disease is found just as often in cold as warm, in high as in low climates. In certain localities it occurs more frequently in the spring than the other seasons, as is the case in Philadelphia. In New York there is no difference in the number of cases reported in the spring and autumn. It is supposed to occur more frequently in those months in which there are the largest number of cloudy days, snow falls or rainy weather and when the barometric changes are greatest. I believe the negro is the most fortunate as far as immunity is concerned; the purer the blood, the less liable he is to suffer from chorea. It is found more frequently among the Jews, Germans and Portuguese.

I find that various authors have different classifications for the many forms of chorea. I am rather partial to Dana's classification, which is as follows:

1st. Common or Sydenham's chorea.
2nd. Hereditary or Huntington's chorea.
3rd. Convulsive tic.
4th. Hysterical or (called by some authors) chorea major.
5th. Local endemic, including electric chorea, described by Bergeron and Dubini.

The more common cases are those of simple or Sydenham's. The muscular disturbance may begin by slight contractions of individual muscles, or fibrillary wavy movements increasing in severity until there becomes a complete spasmodic contraction of the muscular fibre. The disease is usually preceded by a change in the patient's temperament, in which he may become irritable, dull, indifferent and absent-minded, or suffer from pains in different parts of the head, due to the increased arterial tension at the base of the brain, which finally involves the larger basic ganglia, causing an interference of or exciting the centres of locomotion and as a result, we have the long train of muscular incoördination and mental disturbance. The child becomes restless and fidgety, is reprimanded for his negligent disposition, or the awkward gait. In the case of a boy, his hands are usually found in his pockets in an effort to restrain these motions, he pounds with one foot or throws his arms carelessly about in an awkward way, stumbles and is constantly dropping things from his hands. In acute cases, the disease usually reaches its height of severity about the latter part of the third or the beginning of the fourth week; as a rule, all voluntary muscles are disturbed. The muscular disturbance begins with irregular movements of the limbs, increasing until all the superficial muscles of the trunk and extremities are involved. This condition may continue day and night although the spasms are always less, and frequently absent when the patient sleeps. These cases may become utterly helpless, are unable to feed themselves, or take the proper care of their bodies and the greater the effort of the will to control the muscles, the more unruly they become. The contractions are sometimes so severe as to require several nurses to restrain or to prevent the patient from falling from the bed to the floor.

Heredity plays its part as a cause of the disease, the cases usually becoming chronic and are by far the most difficult to treat, not that the parents have necessarily suffered from chorea, but that they were of a neurotic temperament. They may have suffered from chorea, epilepsy, hysteria, insanity, or neurasthenia.

I find that Hare in his work on diagnosis says that in convulsive tic, which some authors choose to consider under the head of chorea, the spasms are exceedingly sudden, darting across the face and involving all the muscles of the facial nerves; it is usually unilateral and may be almost constant or may come in spasms, rarely involving the muscles of the jaw, neck or tongue and is caused by the disturbance of the centre of the facial nerve or its trunk, the pathology of which is not understood. The prognosis of this form of chorea is very bad so far as recovery is concerned. The levator palpebræ has been involved and sometimes the spasms are confined to this muscle; when it is we must not forget that this may be a premonitory symptom of exophthalmic goitre and whenever the symptom presents itself the matter should receive serious consideration; this is known as Abadie's sign.

Epidemic chorea is a form that occurs from imitation; the subject imitating another who is suffering from convulsive tic, chorea or other spasmodic contractions of the muscles. It appears to be produced by

suggestion, in which one might almost consider it akin to hypnotism, the suggestion being so strong that the child experiences an irresistible desire to imitate the same. These cases are of short duration, and a change of environment and keeping the child quiet is all that is required.

Electric chorea is that form characterized by lightning-like rapidity, affecting, according to Henoch, especially the muscles of the neck and shoulders of children; Bergeron says it is found in children from seven to fourteen years of age, attacks groups of muscles and affecting one or more members; the head may be thrown in one direction while the arm is abducted or the forearm fixed with a certain rhythm. Dubini has described a form of electric chorea which appeared in Upper Italy, the patient suffering pain in the head and back; the disease may appear at any age, affecting one arm or leg, the side of the face or whole body, or limited to only one side; epileptiform attacks occur and the temperature may be increased. These cases are usually fatal, death being caused by cardiac paralysis or stupor.

Senile chorea, or that affecting the aged, is quite rare and seldom found in women. The prognosis is bad so far as recovery is concerned but becomes chronic and is usually hereditary. This form of chorea must not be mistaken for paralysis agitans or senile trembling. This might happen, as paralysis agitans is a tremorous movement and is sometimes inclined to be spasmodic in nature, particularly if the patient tries to restrain these motions; but there is usually loss of power and a peculiar expression of the face. Taken in conjunction with the history of the case there should be but little possibility of this being confounded with chorea, while senile trembling is usually confined to the head and is constant, seldom varying in its severity; the past history is all that is necessary to confirm the diagnosis of this form of spasm.

Paralytic chorea is that form in which the power of the muscles are partially suspended, or there may be complete loss of power over the same, though the paretic state is never permanent.

Only one part of the body may be affected when the term hemichorea is applied. It is seldom that you find complete loss of power of the limbs.

Dana describes a maniacal form of chorea in which the mind is disturbed, producing delirium and other phases of mental impairment. The patient appears silly, laughing when there is practically no cause and immediately becomes irritable, is dull of apprehension and there may be a total loss of memory. Preceding this condition, the patient suffers from delusions and hallucinations, in rare cases the disease going on to complete idiocy. During the course of the disease, anæmic heart murmurs have been detected in poorly nourished children. Epilepsy has occurred as a result in those cases which suffered from intense mental disturbance.

The fatigue produced by the continued efforts of the muscles is not as great as one might expect. The appetite is as a rule abnormal, and the patient is always ready for his meals though it may be impaired.

The urine may pass involuntarily or be retained and the patients are usually constipated. The sensory centers are seldom disturbed and the pulse and temperature are normal, except in the maniacal form.

There is still another peculiar form of chorea that is mentioned in Elliott's works which may be termed choremania or epidemic impulse to dance. This has occurred in Kentucky and other parts of the country, in the earlier part of the century, but more frequently in middle Europe. It usually occurs from excitement caused by religious revivals, when from fifty to several hundreds of people form a circle and join hands, dancing and shouting until they become so exhausted that they fall or faint away, resembling the old indian ghost dance. I fail to see the choreic nature of this performance and should call it transient mania, due to the hypnotic influence exercised over the audience by the evangelist, who they look upon as having unusual divine power, thus rendering themselves more susceptible to his suggestions.

Chorea may continue from three to six months or, in more protracted cases, from six to eighteen, there is a tendency to recurrence in about one-third of all cases, the intervals ranging from three months to three years, but usually one year; it seldom recurs more than once, although there are cases on record where the disease has returned as often as eight or nine times. Chronic cases may continue for years and are usually hereditary or due to organic heart lesions, which give us the majority of fatal cases. Patients having suffered from chorea usually remain more or less nervous and may develop hysteria, epilepsy, insanity, or merely become erotic.

Chronic chorea of the adult usually becomes permanent, the mind becoming impaired as the disease continues from year to year and finally die from dementia.

In considering the cause of the disease it appears that the rheumatic poison, as it were, is one of the most frequent causes, in that the disease either immediately follows an attack of rheumatism or begins soon after; perhaps owing in some cases to the organic heart disease which is frequently induced by rheumatism. Endocarditis is a frequent cause, and has developed during the case of chorea; as many as one-third of the cases that are not due to rheumatism have suffered from organic heart trouble. Pregnancy, more particularly in primipara under the age of twenty-six, has produced chorea, fright has produced at least twenty-five per cent. of the cases; intestinal irritations produced by worms or other causes, also reflex irritations produced by eye strain, diseases of the nose and sexual organs as well as diseases of the sigmoid flexure and the lower part of the bowel.

There is very little to be said of the pathology; it is supposed that the grey matter of the cortex as well as the meninges are involved, yet nothing characteristic is known.

O'Connor states that the reflexes are seldom if ever disturbed, while Dana says that the deep reflexes are somewhat lessened and the knee jerk absent. He also says that when the disease reaches its height the urine contains an excess of urea and phosphates and that the specific gravity may be increased, and says the pathological features are those

of hyperæmia with dilatation of the vessels, small hæmorrhages and spots of softening involving the cortex and meninges. In chronic cases there usually exist peri-vascular dilatations and increase of connective tissue, producing sufficient irritation to excite irregular discharges of nerve force; as a result we have the choreic movements. The symptoms seem to suggest central origin. The fact that the disease may involve only one side or half of the body, the mental state that is occasionally developed, the patients being generally quiet at night and the more the will is brought to bear upon the action of the muscles the more they become excited, is a strong argument in favor of central derangement.

The diagnosis is easy and should not be confounded with any other disease, unless it might be hysteria. Some authors describe such a form of chorea, but it is not true chorea but the hysterical chorea or chorea major mentioned by Dana. The prognosis is usually favorable, the majority of the cases recovering excepting in chronic forms and even then favorable as far as life is concerned, unless caused by organic heart trouble. The treatment practically amounts to the thorough study of the remedy. The most important consideration is rest and quiet, even to placing the patient in bed, frequently bathing the spine with cold water and alcohol.

O'Connor suggests the following as proving the most successful in his hands; ignatia, tarantula hisp., cimicifuga, and pulsatilla. He states that he has seen remarkable results from the use of Fowler's solution in the hands of the allopath, yet arsenic as low as the second trituration has failed to give satisfactory results. He is of the opinion that the potash found in Fowler's solution is the principal curative agent, and suggests that causticum ought to be more frequently used by the homœopaths.

Mygale has never proven to be of any benefit to him. Farrington says, this is one of our best remedies for uncomplicated cases when the patient is low spirited and depressed.

Drs. Goodno and Bartlett mention agaricine 2^x as a routine remedy, and claim to have obtained brilliant results with it.

Elliott gives indications for some twenty remedies, among them are agaricus, absinthium, belladonna, hyoscyamus, nux vomica, stramonium, and veratrum viride.

I might mention calc. carb. as it proved curative in several of my cases when given in the 30th potency.

In regard to electricity I cannot say much to encourage its use from my personal experience in chronic cases. I have used it in every form on several such cases without any benefit, in fact they seemed to grow worse. The tonic and sedative effect of electricity ought to be of importance in the more common phases of the disease. Elliott claims brilliant results from it and prefers the static, stating its effects are often surprising, curing cases that heretofore have resisted all medication. I have been very much discouraged in the treatment of chorea in the chronic form, and after having exhausted my patience and

medicines placed the patient on a strict diet, avoiding all stimulating foods and drinks, giving them plenty of milk, vegetables, cereals, fruit and nuts, directing the patient to rest after each meal, avoid excitement and to educate the muscles to act slowly by the use of slow calisthenics; this in conjunction with massage and the indicated remedy have been the most successful.

REPORT

OF THE

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

SHALL WE CUT THE OCULAR MUSCLES?

E. H. LINNELL, M. D.
NORWICH, CONN.

In casting about for a subject that would be appropriate to present for your consideration, the remark made by a general practitioner at the meeting of the Ophthalmological and Otological Society at Atlantic City last June occurred to me. He said: "Tell us what to say to our patients when they ask us whether to have their eye muscles cut. That is what we want to know. So much indiscriminate cutting has been done and so many individuals have been left in worse condition than previously, after one or several tenotomies, that it is very difficult for us to know how to advise our patients in this matter."

This is a very important and a very practical question and in deciding it there are many points to be considered. My first reply to such a question would be: Refer your patient to a careful, thorough and especially a conservative oculist. The majority of muscular inequalities, short of absolute strabismus, do not require tenotomy. It is true that much indiscriminate cutting has been done, and sometimes to the detriment of the patient. Like all new procedures it had its over-zealous enthusiasts at first, but the pendulum after a time began to swing the other way, and we have learned to understand better the indications for surgical treatment in these cases.

In the first place it is necessary to determine whether we have to deal with a true or a false heterophoria—a functional or an organic affection. The relation between accommodation and convergence is so intimate that the two actions are necessarily combined. Branches of the same motor nerve, the third, are distributed to the ciliary and to

the extrinsic ocular muscles. The simultaneous adjustment of the focus and the fixation of the near object is essential for distinct binocular vision. Convergence for a given distance under normal physiological conditions is associated with a definite amount of accommodation requisite to accurately focus upon the retina the rays of light coming from that distance. Hence when the accommodation is excessive as in hypermetropia, there is a tendency to increased convergence of the visual axes, and one of two conditions will naturally result. Either the internal recti become over developed, leading sometimes to actual strabismus, or there is a weakness and insufficiency at the near point which incapacitates the individual for continuous application.

The reverse holds true in myopia, viz.: vision at a given distance is associated with less than the normal amount of accommodation. It is important to remember this fact, that in both hypermetropia and myopia the normal physiological relations between accommodation and convergence are disturbed. By paralyzing the ciliary muscles we can temporarily suspend this association of convergence and accommodation and the results will yield valuable indication for subsequent treatments.

If a true heterophoria is found to exist we should endeavor carefully to determine its nature and cause. Have we to deal, for instance, with a too strong internal rectus from over-development or faulty insertion, or with an external rectus that is inherently weak from lack of development or that has become so from over-stretching by its contracted opponent? This point is one that is absolutely essential to determine before deciding upon a given line of treatment. To arrive at a diagnosis an understanding of the relative strength of the individual muscles under normal physiological conditions, a careful testing of each muscle separately and a comparison with the healthy standard is requisite.

Having settled these points the oculist is then in a position to intelligently consider the question of treatment for any existing heterophoria. In the first place he should endeavor to ascertain whether such a condition is the cause of existing symptoms. I have repeatedly called attention in print and otherwise to the influence of muscular anomalies in the causation of headaches and other functional nervous affections, but I think those who are familiar with my exprsesions on the subject will remember that I have always been conservative. It is true here as with other sources of nerve strain that the effect varies greatly with the individual. One of a highly sensitive temperament will be seriously affected by a slight deviating tendency, while, on the other hand, a person of a phlegmatic temperament will suffer no apparent inconvenience from a heterophoria of a considerable degree. The effect depends not only upon the temperament of the individual but upon the kind of work to which the eyes are subjected. Naturally the student, the bookkeeper or the seamstress will suffer more inconvenience than one whose occupation does not require close application. Therefore I wish to emphasize the statements that many cases, perhaps the majority of slight deviations, do not require any treatment. They are as a rule associated with some form of ametropia, and a careful

correction of the refraction is often followed by a restoration of the muscular balance, or at least a disappearance of the asthenopic symptoms, which is all that is desired. In the first instance it was a pseudo heterophoria dependent upon the unconscious effort to see distinctly and not a structural defect of the muscle or its insertion. When that is true it may disappear gradually or only after considerable time. The fitting of the frames is of almost equal importance with the selection of the lenses. The glasses should rest horizontally on the face and the centre of the lenses should correspond accurately to the centre of the pupils. Otherwise a prismatic effect often results which is a direct source of muscular strain.

When the asthenopic or nervous symptoms do not disappear after correcting the refraction or when there is no ametropia, treatment especially directed to the relief, a cure of the heterophoria must be undertaken, and the problem is this: Given an inequality in the strength of two opposing muscles, shall we weaken the stronger one or develop the weaker one? Two strong muscles are obviously more desirable than two weak ones, and this is what we should aim to accomplish. If the weaker is of normal strength and the stronger largely exceeds the physiological standard we may be justified in at once making a tenotomy. In the very large majority of cases however it is better to try to strengthen the weaker muscle. This is more successful with the internal and the vertical recti than with the externi. Personally I have had very little success in trying to develop the external recti. Here again judgment and care are required. I myself am an illustration of it. I formerly suffered with insufficiency of the interni, as it was called twenty-five years ago. Under treatment by an oculist of reputation the muscles were developed from an ability to overcome the deviating tendency of a prism of 10°, base inward to one of 70°. This was so much in excess of the normal physiological standard that the balance was thrown the other way, and it was ten years before I recovered from this injudicious overtraining. The use of prisms and of electricity are the most effective means in my hands for accomplishing the desired result. Careful tests for both distant and near vision should be made with the modern instruments of precision at frequent intervals during the treatment, to ascertain when equilibrium has been reached, for the normal relation of the different sets of muscles varies in different individuals.

Failing to establish orthophoria in this way we have to choose between palliation and a resort to surgical measures. We may often relieve the symptoms, and secure free use of the eyes by decentering the lenses, or by combining with them prisms with the bases turned in the direction of the weak muscles. Personally I use prisms in this way very frequently and with the best results. I believe it is better practice than to make a tenotomy in a case of slight deviation, because so much judgment and accuracy are required that even the most expert operators cannot always estimate in advance the effect of a graduated tenotomy. Hence the repeated cutting, first of one muscle and then another that has been practiced to the detriment many times of the

patient and the bringing into discredit of a procedure which is legitimate and often brilliant in its results, but which in my judgment should be kept in reserve as a dernier ressort.

To recapitulate briefly, in answer to the questions quoted at the beginning of the essay I will say:

1st. Send your patient to a thorough, careful and conservative oculist.

2d. Be sure that all errors of refraction, even though slight, have been carefully corrected. I am satisfied from my own experience that many nervous and asthenopic symptoms result from very slight refractive errors in persons of a susceptible nature; although I am aware that many oculists differ from me in this opinion.

3d. Be sure that the frames fit the patient's face properly.

4th. Be sure that a reasonable trial of systematic exercises for the development of the weak muscles, either with or without the use of electricity has been made.

5th. If you have eliminated other sources of reflex disturbances so that you are reasonably sure that the existing symptoms are directly dependent upon the heterophoria, advise tenotomy.

The following cases illustrative of the foregoing remarks may be of interest:

Case I. Miss F. is a cashier in a large mercantile house, and works all day by an incandescent electric lamp. She complained of a constant dull pain in her eyes and head. She had a hypermetropia of the right eye and a compound hypermetropic astigmia of the left eye together with a left hyperphoria of one-half degree, an esophoria in distant vision of 1° and an exophoria in accommodation of 4°. Correction of the refraction gave her entire relief without treatment for the heterophoria.

Case II. This case illustrates the result of training. R. D., aged 25, a student, complained very much of asthenopia, of twitching of the lids and of frontal headache. He had been wearing +0.50Ds., O. U. for near work.

Examination showed V., O. U.=15/15. He accepted glasses as follows, viz.: +0.50Ds.+0.25Dc., ax. 90°, O. D., and +0.25Ds.+0.25Dc., ax. 75°, O. S. He had a right hyperphoria of 8°, an exophoria of 16° in distant vision and of 19° in accommodation. By exercise with prisms the hyperphoria entirely disappeared within a week, and in three weeks the exophoria was reduced to 1° in the distance and 3° at the reading point. Sphero-cylindrical lenses as above were prescribed for constant use with entire relief of all his symptoms. I heard from him a year and a half later that they were still entirely satisfactory. In this case agaricus 6^x was also prescribed, and undoubtedly helped in the cure of the pseudo hyperphoria which was evidently caused by spasm of the superior rectus.

Case III. This case illustrates the effect of decentration of the lenses. Mrs. A. complained of headache after using her eyes and a feeling "as of sticks in them." She had been using +2. Ds., O. U. for near work. Her vision was 15/15 with each eye. She accepted

+0.25Ds.+0.50Dc., axis 90° O. U. for distant vision and required +2.50Ds. in addition to the cylinders for near work, on account of presbyopia. She had an exophoria of 10° in accommodation. The lenses for reading were decentered 3mm. inward, thus giving the effect of a weak prism for the relief of the exophoria.

Case IV. In this case I made a tenotomy of the stronger muscle. Miss L., aged 15, came to me complaining of frequent headaches, inability to use her eyes, chronic conjunctivitis and scaly blepharitis. She was using glasses which were not satisfactory. Upon examination I found the following conditions: V. O. D.=3/200. With—9Ds. ⊂ 1Dc., ax. 20°, V=15/30, and the radiating lines of the astigmia chart were all seen with equal clearness, V. O. S.=3/200. With—8Ds.⊂ 1.25 Dc., ax. 180° V.=15/20, and the lines were right. L. h.=10° and left eye standing noticeably higher than the right. Es. 2½° for distance, but no lateral deviation at the near point. Accommodation was quite deficient. With—5.50 Ds. and cylinders she could read Sn. 5 with ease, but not nearer than 10 inches. She frequently noticed that the lines overlapped in reading. A prism of 1/2° base down before the right eye produced diplopia with no power of fusing the double images.

By exercise with prisms, the hyperphoria was reduced to 8°. A tenotomy of the left superior rectus was done, which reduced the hyperphoria to 4°. Glasses were then given as follows: O. D.—5.50 Ds.⊂1Dc., ax. 20°, prism, 2° base up. O. D.—5.50 D. S.⊂1.25Dc., ax. 180°, prism, 2° base down for near work; and —8Ds. O. U., with cylinders and prisms for distance. Perhaps in this case a second tenotomy of the inferior rectus of the right eye would have been preferable to wearing the prisms, but the result was entirely satisfactory. She recovered from her headaches, her accommodation became normal, she resumed her studies and went to college.

DISCUSSION.

F. PARK LEWIS: It is now about twenty years since the ophthalmological world has had the tenotomy proposition under advisement, and few questions in surgery have met with more enthusiastic endorsement on the one hand, or more absolute condemnation on the other than has this. One group of men has broadly claimed that many functional and even organic disturbances have found their origin in ocular muscular imbalance, while another—mostly composed of the older and more experienced authorities in ophthalmology—have taken a much more conservative view and have deprecated what they have regarded as an unscientific and unsatisfactory procedure. Now while we have all of us seen remarkable results follow the judicious employment of this measure, we have also seen repeated tenotomies followed by unsatisfactory or disastrous results; there is therefore a recognition of the fact, on the part of most men of experience, that manifest phorias by no means carry with them one invariable war-

rant for surgical interference, they simply emphasize the necessity of most crucial and repeated examinations before surgical measures are employed. As the writer of this paper has judiciously pointed out, an exact mydriatic (preferably atropine) test must be made before tenotomy can be considered. There may be a very rare exception in which the cyclopegic is omitted, as in elderly people with a tendency to glaucoma, but these are so exceptional as to scarcely require mention. It is astonishing what a large proportion of local inflammatory or reflex nervous troubles can be overcome by an exact adaption of suitable correction glasses. It may almost be said that ophthalmology has taken on a new development since it has been recognized that the two eyes in the same patient have not by any means always the same focal value, that the astigmia may not always have corresponding angles; that a badly fitting frame, or an imperfectly centered lens may intensify instead of correcting the refractive error. In a word, modern refraction is a new thing; and in its highest evolution we relieve not only asthenopia, not only headaches, not only nervous dyspepsia and the other train of distressing conditions of which so much has recently been written, but to the astonishment of the ophthalmologist himself we cure inflammatory disease of the eye. Frequently conjunctivitis, blepharitis, chalazia, keratitis, and even intraocular diseases which are produced by the constant teasing of the strained muscles of accommodation, are relieved by judiciously applied lenses; even glaucoma is unquestionably influenced, if taken at an early stage, in the same way. This does not mean glasses bought from the "eye specialist" or "refracting optician" et hoc genus omni—nor yet when prescribed by the hasty or indifferent ophthalmologist, but only as a result of a patient and accurate determination of the defect in each particular eye and its absolute correction. This having been done, the problem is simplified by eliminating perhaps seventy per cent. of our cases; ten per cent. more are constitutional neurotics with uterine or spinal irritation or hysteria, for whom neither refractive correction nor tenotomy will prove beneficial, but who require general sanitary modes of living—a sufficient amount of sleep, cold baths, proper exercise, suitable psychological hygiene, sexual abstinence.

But there still remain the others—sensible, level-headed people whose refraction has already been carefully corrected, or who may be emmetropic, and for whom ocular orthopedics are insufficient—on whom it has been incontestably demonstrated that the muscular attachments are abnormal, and who are profoundly affected by the ocular struggle that they must constantly maintain in order to keep focal fixation; with these anything other than tenotomy is waste of time, and from these we get the most brilliant and permanent results. It is then a question of nicest discrimination, and to the question, "Shall we perform a tenotomy?" the answer can be given positively. It is this: If there is any doubt about it don't do it, and in any event don't do it until it has been conclusively demonstrated that other corrigible conditions are not entering into the case. Even in

these chosen cases a favorable result cannot be absolutely predicated, but in the large majority of them when performed by a skillful and experienced surgeon a complete (rarely a partial) tenotomy will give almost marvelous results.

As in the past, I repeat my absolute conviction that in neurotic conditions, in nervous troubles, in dyspeptic troubles, in the various functional and organic diseases, we have not made a careful examination of our patient and we do not know what we are dealing with until the eyes have been carefully tested. During the last year I have had an opportunity of making a number of examinations of those who are inmates of state hospitals and I have been astonished at the large preponderance of cases that I have found among those who make no complaint of eye-strain, and yet I find focal defects of so marked a character that they must enter very much into the nervous condition. Now I think the conclusion which is wholly warranted by investigations of this kind is this: Not necessarily the eye-strain is the one cause on which these neurotic conditions depend, because there are other elements that enter very largely into it—from our unsanitary methods of living. The system being loaded with toxins simply makes any reflex eyestrain peculiarly trying and very much more likely to produce disastrous results. But a knowledge of the condition of the eyes is essential.

REPORT

OF THE

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

"Nasal Stenosis and Its Relation to the Voice," - HORACE B. WARE.
"Aphonia," - - - - - - FRED D. LEWIS.

NASAL STENOSIS AND ITS RELATION TO THE VOICE.

H. B. WARE, M. D.
SCRANTON, PENN.

In the brief space of time I have had to prepare this paper, I have not been able to give the subject the attention it should have had, and my only object is to mention a few things that may elicit a general discussion that will be beneficial to all.

In the first place, nasal stenosis may be caused from anything acute or chronic that obstructs free nasal breathing. Acute congestion, as from traumatism or sudden changes in the temperature and from par-

ticles floating in the air and carried into the sensitive nasal cavities, as pollen of flowers, horse dust, etc. Chronic, when turbinated bones are enlarged or the nasal septum is deflected or overgrown or the soft tissues covering these parts overgrown from repeated attacks of inflammation, or the giving away of small localized areas, causing polypoid or adenoid growths along the nasal tract or naso-pharynx.

The anatomy of the nasal cavities and larynx is rather complex and I will not go into detail. On examination we find the principal nerves supplying these two organs are branches from the facial and pneumogastric. Both have a common origin at the floor of the fourth ventricle and also both are closely connected through their ramifications. These two great nerves supplying the most vital sections of the anatomy are naturally sympathetic, being such close neighbors with one another and having originated from the same locality, and also one supplying sections from which the vital blood supply is controlled. Thus we have the condition.

It takes no expert to understand how a constricted nasal passage may cause the tonsils to enlarge from over-activity. To demonstrate this, hold the nose with one hand, allowing only a small amount of air to pass through, and with the other feel the action of the throat at each inspiration and expiration. This condition is often found in young people who have an aspiration to sing or elocutionize. We know a rubber ball thrown against a resisting body will rebound, the returning force being regulated by the power exerted in the throwing and the distance and the resisting force with which it comes in contact. Thus, for words ending with certain consonant sounds, b, d, g, and others—the nasal passages must be free to allow the (I may say) exhaust of the word to pass through, otherwise there is a discordant sound and the force exerted to produce this tone rebounds and strikes the vocal cords in the same ratio as the throwing of the ball. The result of this back action is to soon tire the vocal cords and to stop the natural lubricating secretions and the voice becomes husky necessitating a public speaker to sip water frequently when speaking. This same thing holds good with singers, and from not being able to moisten their throats the voice soon becomes exhausted and a clear tone cannot be held; many a singer with that divine gift is relegated to that class "who used to be" through either their own or physician's ignorance. When there is some interference with the sound waves either in the naso-pharynx or pharynx, as when the tonsils are enlarged—though both usually exist at the same time—there is a peculiar flatness and roughness to the voice as though the tongue were constantly against the roof of the mouth when talking. There is no resonance in the voice and it sounds as if one was talking into a tin cup and yet there may be at the same time fair nasal respiration. Have the patient breathe hard with one's hand on the throat; a diagnosis may be easily arrived at without any ocular examination and a differential diagnosis at the same time made from this and from a nervous origin when the voice is affected. When the air ceases to go through nature's filtering and heating process and comes in direct

contact with the sensitive pharynx and larynx it is apt to inflame these parts, for the temperature of the air is raised several degrees in passing through the nose, as has been shown by repeated experiments.

We all know the moment any foreign body enters the larynx; the vocal cords involuntarily close tightly against it and one must cough or clear the throat until the particle is expelled. A spasm of the adductor muscles may ensue which may last for some time, causing intense suffering, the voice remaining thick and husky for some time. If this condition is produced from an acute closure of the nostril, of course when a similar chronic condition exists the larynx is bound to suffer, producing a chronic inflammation and thickening of the vocal cords; hence singers' and public speakers' sore throat. The pneumogastric nerve supplies also the heart and stomach. When one of these organs is affected, naturally the other sections supplied by the ramification of this nerve are often affected; hence no one would advise a patient to pass a bodily examination for life insurance after a hearty meal; nor would any public speaker or prima donna excel in his or her vocation by going directly from a hearty dinner on to the stage where any test of his or her vocal endurance is likely to be called upon. This is only known to them by experience that it is so. Is this condition only caused through the influence of the pneumogastric nerves which control the voice, or are branches from the facial nerve stimulated sufficiently from the pneumogastric that thus the nasal mucous membrane is caused to become engorged with blood at the same time nature supplies the stomach with blood for digestion? If this is the cause, which I believe it to be—for after a very hearty meal the nose is generally somewhat stopped up and one feels drowsy, the same condition, though only transient, exists as when one is suffering from acute coryza. If this stoppage of the nose may be the cause of the voice to soon tire out, we specialists must not be over-sanguine in our promises of relief from existing nasal stenoses which we believe to be the cause of interference of clear vocal tones in our patient; but should also investigate further and determine whether the stomach and heart's action may not also be affected, although these organs may be affected from a nasal closure. In any case the proper course in treatment is to always remove the bony or soft tissue and thus to give a free nasal air passage; if done properly the great majority of our patients will get well or be so far relieved that with proper exercise their vocal powers may be restored.

DISCUSSION.

F. PARK LEWIS: Dr. Ware's theory is a new one to me, that of the rebound striking the vocal chords, and it is very interesting. I always thought that the irritation was dependent on the fact that the air, not passing through the nose, must pass through the mouth, the chords become dry and irritated that way. The importance of thoroughly clearing the nasal passages I think is growing more and more. Air-space must simply be opened. If there is hypertrophy that cannot be

relieved, it must be removed. There is no other way that free breathing space can be obtained, and without that all the conditions of ill-health follow. It is not always directly relieved, but the necessity for freeing the post-nasal space and vault of the pharynx has been impressed largely on my mind in certain forms of ear troubles, and this should be suggested. In that class of children who are subject each winter to acute attacks of otalgia and inflammation of the ear I have found that when the pharynx is examined during the interval when there is no suffering, there may or may not be adenoid growths, but there is certainly hypertrophy, always, constantly, and I find that by removing this granular tissue, by scraping it from the throat, in many cases it relieves the tendency towards repeated inflammations of the ear which comes from the fact that the swollen throat tissues readily become further congested, occluding the eustachian passages, the resultant inflammation extending to the ear. In these cases in which there is a tendency to ear-ache, almost inevitably you will find disease in the throat; hypertrophied tonsils, etc., and relief comes from the removal of these tissues.

J. F. ROE: Hypertrophy of the lingual tonsil affects the voices of opera singers and especially those of public speakers, preachers and various public speakers. I have found in many singers, who after one or two efforts in the evening would become hoarse, that the lingual tonsil was the cause of the trouble, perhaps the entire upper part of the epiglottis, and when that was removed it would give relief, Growths in the pharyngeal vault have a good deal to do with the voice. I believe that many cases of hypertrophied middle and lower turbinated are caused by adenoids in the throat, not allowing the proper passage of air nor ventilating these passages properly.

FRED D. LEWIS: I would like only to add to this, as I have stated in my own paper on "Aphonia," which will follow, that the most frequent cause of faulty voice in my experience has not been nasal stenosis, but impaction of the middle turbinated body, even when breathing has been perfectly free. I have often found this condition, especially in sensitive nerve centres directly opposite to it; there has been decided defect in the voice which has been eliminated by removal of the middle turbinated.

DR. WARE: The point that I want especially to bring out in the closure or obstruction of free nasal breathing is that of the air-words ending with certain tones. If when the nose is stopped up, as frequently it is with a very severe cold, one would get up and say "Good morning," if the nose is not free to allow that "exhaust" air to pass through there is a discordant sound. It may be a closure in the anterior or posterior nasal cavity, it may be in the pharynx, but if there is a closure or obstruction, the tone is made imperfect.

APHONIA.

FRED D. LEWIS, M. D.
BUFFALO.

Although aphonia is but a symptom, yet it is one that I consider worthy of special attention. The causes of this distressing condition may be various; as the tendency of the successful treatment of disease to-day is to eradicate the cause, so in cases presenting with this symptom the cause if possible, must be determined. Often the examination with the laryngeal mirror will reveal to us all that we desire to know, while at other times a very careful study of the case will be necessary. The most common causes are as follows: reflexes, tuberculosis, nodular laryngitis, central or local paralysis, diphtheria, rheumatism, syphilis, anæmia and inflammations.

To consider exhaustively each of these diseases in their relation to the throat would be impossible in the time allowed to this paper. Let us then take a few of the principal causes and review them briefly. First, in my experience stand reflexes; among the reflexes, those resulting from an enlarged middle tubinated body pressing on the septum, or pressure in the same locality caused by nasal polypi, are most frequent. However, septal spurs or ridges or pharyngeal hypertrophy or congestion may be the exciting cause. How useless would be the administration of a drug or any local application without surgical treatment in such cases! Some years ago I suffered with an almost complete aphonia, doing for it whatever might be suggested to me without any relief, until a nasal polypus was removed, when my voice returned.

I believe also that frequently the generative organs are the exciting cause; this can readily be understood when you notice the marked change in the voice often resulting from castration or ovariotomy.

Following the reflexes it is but a short step to nervous or hysterical aphonia. Here is where the physician may make for himself the record of a brilliant cure, mislead himself as to the action of some particular drug, or worry himself needlessly over an apparently stubborn or intractable case. The diagnosis must be well established that the case may be properly handled. After the exclusion of reflexes the symptoms, the appearance in the examination with the laryngeal mirror and the age and sex of the patient, will generally give the required information. The symptoms are generally negative; there is no soreness, no pain, swallowing is accomplished without difficulty, but the patient has no voice. This is also the case in reflexes or paralysis; but with the hysterical patient there is frequently a normal cough or laugh, which is never present in any other form of aphonia. The appearance of the vocal cords in attempted phonation shows some movement, but not complete apposition; the movement of both cords

is symmetrical. In paralysis one cord is usually affected, or when it is bilateral there will be complete inaction. Again, hysterical aphonia generally occurs in girls between puberty and the establishment of the menses. The treatment should be directed towards establishing in the mind of the patient a thorough confidence in the ability of the physician to affect a cure. A remedy, or even sac. lac. may be given with the assurance that the voice will return at or before a given time, or some simple or irritating preparation or galvanism applied locally with the same assurance.

My first case of hysterical aphonia gave me considerable anxiety. I could find no cause whatever for the loss of voice; the patient was very nervous and feared further trouble during the night, as the attack had come on quite suddenly early in the evening; the family stood around awaiting my decision, and I did not know what to do. I took all the symptoms I could obtain, and relied on the administration of the indicated remedy. The girl had made an imperfect attempt at her first menstrual flow the month previous. The next evening I was again summoned and changed the remedy. The same proceeding was repeated the evening following. There being no further call, I presumed that homœopathy had added one more leaf to her crown of laurels, until a month afterwards I met her sister and asking how the patient was she informed me that having gone to another doctor he used the cautery at the base of the tongue, and the aphonia was cured. I now see that my indecision acted unfavorably, and the impression conveyed by my colleague, with the assistance of the hot platinum point had effected the desired result. A mustard plaster to the chest or a hot foot bath might have been just as efficacious.

In tubercular aphonia and nodular laryngitis the mirror should at once determine the cause; the treatment then is simple. In the early stages surgery may be called for in tubercular laryngitis, if the tubercles can be removed; locally apply lactic acid and orthoform. These cases however are usually beyond cure before applying for treatment. The appearance of nodules on the cords is generally due to faulty vocalization; confined principally to singers, and will frequently disappear after proper methods are employed in the use of the voice. Occasionally the removal of the node is necessary.

Cases due to paralysis, diphtheria, rheumatism, syphilis or anæmia must be treated on general lines; local spraying or swabbing being used only for temporary relief.

With all that I have said in my remarks, however, we must not forget that we have a materia medica that is exceedingly rich in remedies acting profoundly on the throat. The most prominent of these perhaps being belladonna, opium, phosphorus, arsenicum, mercurius and plumbum.

I might cite many cases where the indicated remedy has acted like magic in the cure of aphonia. Where hysteria can be excluded and operation is not called for, the symptoms should be carefully collected, studied, and the indicated remedy administered. This remedy may be outside of those drugs I have named, in fact may be one of the

little known and rarely used medicines. If cures can be affected in a few days by internal medication, as I have frequently seen them in cases that were treated unsuccessfully for long periods of time by men who depended on local treatment, they add much to the reputation of the physician and certainly lessen the sufferings of the patients.

The points I would wish to emphasize in this paper are: First, determine the cause of the aphonia; second, if mechanical or constitutional, remove cause either surgically or medicinally; and third, remember the resources at our command in our materia medica and cure by natural law rather than expect results from local measures.

DISCUSSION.

J. F. ROE: The laryngeal muscles are both voluntary and involuntary; the voluntary have nothing to do with the breathing. Any paralysis of the voluntary muscles must be central origin or originate along the line of the nerve supplying them. In this connection we might speak of the laryngeal nerve, which, given off from the vagus, will often produce paralysis in the arytenoid cartilages, and produce aphonia. Inflammation of the vocal cords or arytenoid cartilages may cause aphonia, and here I would speak especially of the arytenoid cartilages—acute cases of aphonia following colds and the grip, and those of a chronic nature from syphilitic origin or from rheumatism.

The reflexes or hypertrophies were spoken of before. I believe that adenoids and hypertrophy of the lingual tonsil have much to do with causing aphonia. I have seen one case where the aphonia would occur in the morning after the singer had used the voice with a little effort; the case was entirely cured by removing the lingual tonsil and it also relieved to some extent the hypertrophy of the nose. A local cause is very plainly depicted in the laryngeal mirror, but often we find nothing in the laryngeal mirror and nothing in the nose to give us any clue.

DR. WARE: I knew of a girl who was very easily mesmerized. She would lose her voice and about once in every three days come to the clinic, where we would all of us experiment and mesmerize her. We could do it by the mirror—away she would go; one could stick a pin into her or do anything at all with her. We would give her a mental impression, that she should for three days retain her voice. She would go away and talk immediately, but as soon as the "powers" left her, on the third day she would lose her voice. Of course it was a very hysterical case. I have had several of those cases in my practice. I would make an examination of the larynx and the vocal chords and approximate as to whether this was from a hysterical origin or not, and an ordinarily strong, faradaic current has brought relief. There is another cause also which is interesting to me. There was a patient who was suffering with aphonia for something like two or three months. She would be relieved and then get worse. Every time she would take cold her voice would become thick and husky. Examina-

tion showed complete closure of one nostril and a bony spur on the other, both of which I removed. I should have said before that there was paralysis of both sides, which was entirely relieved after the nose was cleared; that unquestionably was the cause of this aphonia. She did have some enlarged tonsils, but otherwise the throat was free, and I do not believe that any other treatment possible would have relieved that case.

FRED D. LEWIS: I agree with Dr. Roe as to the effect of the lingual tonsil on the voice. We do not thoroughly appreciate the importance of that and don't, most of us, make sufficiently careful examinations in that quarter. Where it is hypertrophied there is no question it has not only an effect upon vocalization, but, a very marked one on the general constitutional condition of the patient; an enlarged lingual tonsil is a diseased tissue throwing off a diseased secretion which, taken into the stomach with food must necessarily disturb the digestion and the physical condition of the patient.

In regard to this particular case I spoke of, I am satisfied with the fact that hysteria as a general thing has some condition back of it which promotes it; in this particular case the hysteria was brought on by the beginning menstrual life of the girl and when that was established the hysteria disappeared.

JOHN L. MOFFAT: When giving a list of the principal remedies acting on the throat the writer, to my surprise, omitted causticum. Causticum is especially useful in paralytic aphonia; for the catarrhal form ammonium causticum is a valuable remedy.

DR. LEWIS: I accept Dr. Moffat's correction, but phosphorus has been my most valued remedy.

REPORT

OF THE

BUREAU OF PUBLIC HEALTH.

"Progress of the Year," - - - - - J. W. LESEUR.
" Sanitary Sewerage in the Smaller Cities and Towns of this State," F. P. Warner.
" Heredity, Environment and Food in their Relation to Consumption," EMILY F. SWETT.
"Sanitarium Care of Consumptives," - - HOWARD PERCY DEADY.

CHAIRMAN'S ADDRESS, THE PROGRESS OF THE YEAR.

J. W. LESEUR, M. D.
BATAVIA.

In the Bureau of Public Health and Sanitary Science the progress during the year, while not great, has been of intense interest. It is in line with the general trend of medical thought and the endeavor to accomplish as much as may be by the use of what is termed preventive endeavor. Probably in the department of contagious diseases, this State has been more agitated during the past year than at any time during the preceding decade. We have had in various portions of this State, notably in the western and southwestern portions, several cases of the disease which perhaps most of all is loathed if not feared among the contagious diseases, and it is a matter of regret as well as of shame that in numerous instances small-pox has been disseminated through the negligence—I will not say criminal carelessness—of the attending physicians. Perhaps there has been no time within the past twenty years when so many cases of small-pox have existed within the confines of the Empire State as during the past year. It is a matter of satisfaction that these diseases are now thoroughly recognized and are being rapidly suppressed, and it is a matter of congratulation that the efficiency of the State Board of Health, in its various local branches, is becoming realized and more thoroughly appreciated with each succeeding year. Probably every physician in the State has at one time or another been brought to consider the enormous power which is given to the State Board of Health and to the local Boards of Health. I think it is a matter of satisfactory knowledge to most

of the physicians of the State, that the almost unlimited power of the State Board is generally used with discretion and with fairness. I think there is a feeling among some of the physicians of the State and perhaps this is pre-eminently true of the physicians of the larger cities, that there are times when the power of the local Board of Health is used in a way that seems to be oppressive, and if I were to make any recommendations along the line of legislation it would be that something be done looking toward the enactment of such judicious and careful and comprehensive and concise laws as may reasonably limit, without hampering, the efficiency of the local Boards of Health. We can readily see why it is transcendently important that the local Boards of Health should have almost unlimited power. It is equally important that this power be not misused; and where the Board has the right to make its own laws and then to enforce them arbitrarily, no power restrains them except the transcendental power of the Supreme Court. There is danger that over-zealous and over-energetic and not adequately intelligent physicians on the local Boards of Health may, in their endeavor to be efficient, be sometimes unjust, and it is along this line that I believe we may direct our thought with profit and we may endeavor perhaps in the days that are to come to secure legislation that should be to our advantage.

Another item of importance to us and one that we wish to bring before you in some of the carefully prepared papers is the general treatment and care of consumption. I apprehend that the vastness of this subject and its importance is steadily growing on every practitioner in this state. Ordinary practice brings each physician in the course of his work into contact with some person suffering with this dread disease. Perhaps these two items are the principal ones that should be brought before your notice in considering the progress of Public Health and Sanitary Science during the past year.

SANITARY SEWERAGE IN THE SMALLER CITIES AND TOWNS OF THIS STATE.

F. P. WARNER, M. D.
CANANDAIGUA.

It may seem like a superfluous term to use the words "Sanitary Sewerage" for all sewerage ought to be sanitary, but such is not the fact.

In the smaller cities and towns of the State the plumber is subject to no law and can do his work in the most careless and unskilled manner, and there is no one to molest him or make him afraid. When his work is done he can receive his check for a big fee and there is

no one competent to inspect his work, or require him to test his labor to see whether he has put in perfect plumbing, or not.

Having lived in a town of six thousand inhabitants where there is no law or board to inspect the plumber's work upon the completion of as fine a water works plant and sewerage system as there is in the State, the town was overrun with plumbers wholly incompetent to work in their profession. In one house the writer saw a trap put in reversed from the way it should have been, and in another house, the whole family being taken violently ill with diphtheria, the plumbing was found exceedingly defective, the two-inch pipe of the house being connected with the four-inch tile of the sewer immediately under the cellar wall and no calking or cement being used in making the union. This connection was made about two inches underneath the cement of the cellar bottom, yet the gases from the sewer were so strong in the cellar that one not familiar with the premises had no difficulty in locating the odor by the sense of smell. The owner of the house assured the writer that he gave the plumber strict orders to make the connection beyond the cellar wall a distance of two feet or more. Another instance in mind is where all the plumbers of a town refused to purchase a perfect sanitary trap for surface draining of cellars, saying they made one for two-thirds the cost. This one on inspection was found to be perfectly free from water during a dry season and sewer gases pouring into the cellar as a consequence thereof.

These are only a few instances that have come under the writer's observation, but are sufficient to illustrate the way in which sewerage in the smaller towns has been permitted to be done. This is because the plumber is under no authority and knows that no competent inspector will ever survey his work.

What is the need of these smaller cities and towns in this condition?

Plumbing is a science of its own and no one who has not paid any attention to it knows anything of its art. There is nothing which the general public is more ignorant of than this branch of house building. They have paid no attention to it and cannot understand much of its perplexities if they did. They must need therefore to put this branch of their work into the hands of the plumber and trust to his knowledge and honesty to do this part of their house-building. When we take into consideration the necessity of pure air about our houses and the fearful consequences of vitiated air from sewers, the community has as much of a right to ask protection as they have to be freed from small-pox or yellow fever. On account of the ignorance of the public upon this great question of making our homes healthful, the great need is then of having some way provided whereby this branch should be under the supervision of competent judges.

How can this be done? Towns and cities of several thousand inhabitants can and should have an inspector to oversee every job of plumbing that goes into a dwelling, but the smaller cities and towns may not be able to remunerate a man competent to be a judge on this branch of the work about their homes.

Here the State should have the power to appoint an inspector who could have charge of several villages and who should inspect every house where work is being done, his remuneration coming from the general tax of the district over which he presides. It is, of course, taken for granted, that the inspector should be subject to civil service examination, and the State decide his competency for so important a position. This is reasonable and practicable, because the State should have a right to watch over the health of its inhabitants. Women and children are the greatest sufferers from neglect on this part of the State's duty to its citizens. The time is near at hand when it seems that everything must be done beneficial to the greatest number of citizens. When the few must succumb to the many, and when all public trusts must be discharged in the fear of public sentiment.

First of all in this direction is the duty we all owe to the health of the community. In Cuba and Puerto Rico—and so will it be in the Philippines—comes first the cleaning-up processes and pure water and good sewerage. In these smaller towns we should not be behind the work in the new possessions along these lines, but give every family the security of sewerage subject to the judgment of a skilled apprentice, whose fidelity and knowledge is subject to the laws of the State.

Another nuisance which should be suppressed in the towns and smaller cities is the building known as the outhouse. In the past these houses have been a necessity but as population increases there is more necessity of their suppression. When a village puts in a system of sewerage and a water plant, the conditions are such that the outhouse could cease to exist. They are unsightly and always emit foul odors and should be relegated to the things that were.

No one has a right to have anything on his premises which is a nuisance to his neighbor; no man should have anything in his house detrimental to the health of his family, when especially that nuisance might be the means of spreading contagious diseases over the community.

This condition cannot be brought about as long as the plumber is subject to no law, nor his work to be scrutinized by no one competent to judge of his labor.

We therefore pray that this State shall take hold of this matter in these smaller towns and cities, and give the people the assurance that any man who comes into their house to do so important a work, comes clothed with authority higher than himself, whose work shall be subject to those competent to say that no foul odors can emit from plumbing poorly done.

DISCUSSION.

J. W. CANDEE: It seems that in this paper, Dr. Warner has fixed upon a very practical and timely topic. The more I think of the proposition of Dr. Warner, the more reasonably it presents itself to me. The work to which he refers, as we all know, is in effect now in the

larger cities. In Syracuse it is difficult for a plumber to do a poor job. A competent inspector is in office and it is no easy matter for imperfect plumbing to go in a city of that size. Of course, the difficulties which Dr. Warner alluded to are present in smaller places, and it is a question as to how that can be handled. It seems as if Dr. Warner's thought would perhaps lead to the most practical method. It might at first thought occur that such work could be delegated to the local health officers, but there again the question of inefficiency presents itself as an obstacle. The local health officer knows no more about plumbing than you and I, and plumbing is quite a study at the present day. I have often felt that, unless the conditions could be of the best, plumbing had better not be attempted. The outhouses which Dr. Warner so properly condemns, I am inclined to think are fully as good as plumbing for which thousands of people pay large sums and on which they wholly rely. One important point in relation to poor plumbing is that of insufficient flush. Now plumbing, be it never so perfect, without a proper flush is, as we all know, like "Faith without works." I have been impressed with observations along that line, especially in smaller places and particularly in pretentious houses in the country where plumbing had been introduced. I don't remember having ever seen a perfect job. The plumbing might be technically perfect, but the flush was not there. In a case of that sort it may be as well to use the outhouse and make no effort at all at plumbing. The latter is sometimes as bad as the former. The doctor speaks of the abolition of the outdoor closets—outdoor vaults—in places where city water and sewerage or the public water supply are in operation. Now, that must be taken with caution. It is customary in some places, under such circumstances, to make tight the vault of the outhouse, using that as a receptacle and allowing water to run into it. This has been found to be no improvement whatever, worse in fact for the premises concerned than the old-fashioned closet in the earth. In the question of soil saturation, of course, the proposition would be different, but for the purposes for which plumbing is introduced—better sanitation of the premises—the outhouse in the old-fashioned way leaching into the soil, is better than a tight vault communicating with the sewer and into which water is poured more or less intermittently, but always without thorough flushing.

J. T. COOK: I should say that, in more senses of the word than one this subject came more directly home to us than any topic that could be introduced. The examples which Dr. Warner brings forward of the improper work done by plumbers when not under inspection, are fine samples of the stupidity, combined with avarice, of which plumbers are guilty under such circumstances. One who has been, at any time, in his or her life, so rash as to build a house, can speak feelingly upon the subject, and of these qualities for which plumbers are so notorious, viz.: stupidity and avarice. Dr. Warner has certainly suggested what would seem to me to be the only remedy, namely, State inspection. The principle has already been established by the State that plumbing should be inspected by proper officials

before it be accepted by the owners, and I can see no reason why the Law of 1892, known as Chapter 602, should ever have been limited in its effect to cities only. Certainly the farmers who elect our Governors—I believe Governor Roosevelt acknowledges that—the farmers have a right to have protection from diphtheria and kindred diseases, and if this law has been made so far to apply only to the cities I can see no reason why a method should not be feasible for enlarging its scope. In many towns which have no city charter are beautiful homes which have plumbing put in without adequate inspection, and undoubtedly thereby disease is frequently brought to the owner. The law of 1892 secures both the registration of plumbers after an examination and a supervision of their work, and also of drainage in all the cities of the State. It operates through a Board of Examiners, appointed by the Mayor of each city, and is a plain, practical working law. The suggestion of the writer is as practical as this law. I see no reason why this Society could not properly take time to consider, through its officers, a method for bringing about or encouraging legislation in the lines of Dr. Warner's paper.

F. PARK LEWIS: The evidenced desirability of better sanitary measures throughout the State has impressed all the members of the Society and this matter has been brought up for discussion more than once. The city of Buffalo has demonstrated to an extraordinary degree the value of supervision of sanitary measures, to such a degree that officials throughout the country and elsewhere, even foreign officials, have written and sent representatives to Buffalo to know by what means such a low death rate has been obtained as that which has been secured at Buffalo. Only yesterday, or the day before, one of the health officers of an eastern city, I think it was, wrote our efficient health officer to know how it was, whether it was a fact, because the death rate was phenomenal, but the figures are absolutely correct and the results obtained as shown by his report. Dr. Wende has taken occasion in writing to show what measures have been employed in Buffalo to obtain this phenomenally low death rate. What applies to the larger cities might, with an ingenious application of measures, also apply to cities that are smaller. We have in the city of Buffalo, officials who are among the best men we can find, who inspect the milk, who inspect the plumbing, who inspect the meats and who inspect the sanitary conditions of the schools. The supervisor of plumbing, whose business it is—who is connected with the health office—acquaints himself with the exact condition of the plumbing throughout the city. Now, what I am going to say is this, that this whole question is one that should be very carefully studied and an endeavor made to determine whether it can be modified in its application so that the smaller towns may reap the advantages of like measures, to have the State pay some official who would supervise the plumbing in the locality beyond that of the immediate place in which he lives—the county. Regarding the milk supply and the question of the sanitary condition of the cows, the demonstration of the existence of bovine tuberculosis, there has been a discussion in the last week by one of the State officials who

said that bovine tuberculosis had nothing to do with the same disease in the human family. It might be wise to have a committee appointed or direct the Chairman of the Bureau of Public Health to investigate the condition of affairs in the State government—the hygienic measures in New York—to determine whether any suggestions can be offered from this Society as to the employment of better and more efficient measures in other than the large cities.

M. S. PURDY: I think that the greatest cause of inefficient plumbing in small towns is the desire of the builder to get his plumbing in as cheaply as possible. When the average house is built the contract is placed before a number of plumbers to bid upon. If there is no sanitary inspection, the plumber begins to cut down on the expense of materials either to increase his profits or bring his bid within the amount specified by the builder. Thus you will find in a great many houses the absence of a proper back vent, etc. Then, too, where several traps are connected with a single soil pipe, the flushing of one will cause syphonage and consequent trouble. There is very great deficiency and will be until some method of inspection is provided for. A very excellent measure is for the Board of Sewer Commissioners or Board of Health to prepare certain rules for plumbing which will be given attention by plumbers, and imposing a fine if the rules are not carried out. Ordinarily if the contract allows sufficient leeway in price to put in proper plumbing they will carry out this measure. Then, in the matter of sanitary science in the country, I do not think as physicians we consider the danger in the matter of drainage. You go to many a rural home, and especially pretty well out in the country you will find above the well, the stable, the pig pen and the outhouse and what not and drainage gradually percolating toward the well; you will frequently find typhoid fever there.

JOHN L. MOFFAT: The trouble is with the people more than with the plumbers. It seems to me that this is a matter that could be very properly brought before the State Board of Health. I think that Dr. Lewis' suggestion is eminently practical and proper, that our Bureau of Public Health should be requested to act as a committee and to give proper study to this affair and then see what can best be done, having the legislative committee follow up any such suggestions. It is not only the building of our houses. I know of a case where a person acquired typhoid fever in one of the towns of this State. Slops had been thrown out the window and the whole soil around the house had been impregnated with this refuse. While he was in the city sick his mother and brother at home both died of the same disease. Now, that was not the fault of plumbing. Our reliance must be on the family physician! We ourselves have got to keep at our patients—the physician as he goes around to these houses, especially to the isolated farm houses, has got to be the inspector. He must impress upon those people the faults they are committing and the importance of correcting them.

D. G. VAN OSTRAND: There is another phase to this question. Those of us who are in small country towns where there is no system

of sewers, are often times asked by people who are building houses and who wish to have closets and bath rooms, something about the plumbing and where they should locate their cesspools. I think it is the duty of the physicians in a place without sewerage, to know something about plumbing. During this summer three different times I have been asked to come and inspect a case of plumbing by parties who were building houses and draining into cesspools. I have also been asked to designate the location of cesspools; that necessitates a knowledge of geology, to know the formation of the sub-strata and to know where we are to place them, the direction of the percolation from them into the surrounding wells. Oftentimes folks have driven wells and down below the strata of hard clay, but a great many times they have dug wells and then piped into these wells without any regard to the sewerage of the water; they will locate a cesspool within a very few feet and in soil where the drainage is toward instead of away from the well. And while I do not know that such a physician should know about sewerage, yet physicians who are in touch with the small towns should know something about this question.

J. W. CANDEE: I would like to ask the doctor if he has not noticed a trick of plumbers, where there was insufficient quantity of water, of so adjusting the attachments to closets that the discharge, at the time the flush-cord is pulled will make a great noise but not do much; in other words, economize water. This, in my observation, is a device of plumbers, to give the impression of a nice state of affairs.

HEREDITY, ENVIRONMENT AND FOOD IN THEIR RELATION TO CONSUMPTION.

EMILY F. SWETT, M. D.
MEDINA.

Among the unsolved problems in medical science, pulmonary tuberculosis or consumption holds a prominent place. It is essentially a disease of civilization, and its geographical distribution is co-extensive with that of man himself. It spares no race, nor age and causes in England and the United States more suffering and loss of life than any other single form of disease; more than cholera, yellow fever, typhoid fever, measles, scarlet fever and diphtheria put together. It is estimated to be the death-cause of one-seventh of mankind. More than one hundred and fifty thousand persons die annually of this disease in the United States, or on an average of about fourteen for each hour of the year. It has been aptly called the White Plague.

Repeated experiments by means of culture and inoculations have left no room for doubt in the minds of the scientific world, that the

tubercle bacillus is the immediate and efficient and only cause of tuberculosis in all its forms. Some of the modes of its transmission through dried sputa, milk and meat are fairly well understood.

The conditions of occupation that most frequently predispose to the disease are the generally poor hygienic surroundings, such as overcrowding in poorly ventilated, improperly heated, damp and uncleanly offices and workshops: the inhalation of dust-laden atmospheres; exposure to extremes of weather; the consumption of food that is in no way adequate to repair the tissue-loss consequent upon muscular and mental exertion, and working in cramped and constrained attitudes, particularly such as interfere with the normal action of the heart and lungs. Cutlers, file-workers, stone-cutters and cotton-wool workers show a marked tendency to pulmonary tuberculosis. It has been noted that tubercle bacilli retain their virulence much longer in poorly-ventilated and ill-cared-for houses than they do where there is plenty of sunlight and good ventilation. The condensed breath of human beings, or of the air from damp cellars, makes a good medium for the culture of the tubercle bacillus.

Much has been said of heredity in this disease, and many still hold to the belief that it is transmitted in this way. If by heredity is meant not the transmission of a specific disorder, but of an organic disposition from parents to children; a constitutional deficiency which takes the line of least resistance, then beyond a doubt it is a cause of the disease. The effects of heredity upon the liability to disease appear to be due in part to differences in structure and composition of the tissues and fluids of the body, and to a much greater extent to differences in place and mode of life. So we may say that the tubercle bacillus is affected as to its growth and development by hereditary peculiarities of structure of men. As many individuals are more or less immune against these organisms under ordinary circumstances, so also are certain families and races.

The fact that a large percentage of children born of phthisical parents become tuberculous early in life is not a proof of inheritance, as there is a possibility and probability of infection after birth—it may be in the first days of life.

The United States has become the great "mixing ground of races" and an examination of the vital statistics of different races living under the same conditions as to climate, etc., will be especially valuable in determining the relation of race to tuberculosis.

Referring to the reports of the vital statistics of the last United States census we learn that in 1890 the city of New York contained about 335,000 white persons whose mothers were born in America and 25,000 colored; 400,000 whose mothers were born in Germany; 400,000 whose mothers were born in Ireland; 12,000 Russian and Polish Jews; 55,000 Englishmen and 54,000 Italians. The annual deathrate from consumption was for each 100,000 persons: Colored, 774; Irish, 646; Germans, 329; Americans, 205; Russian and Polish Jews, 98. Corresponding data are found in other large cities as Boston, Washington, Philadelphia, Baltimore and in New England.

Investigation shows the colored race to be shorter lived than the

white; that it has a very high infantile mortality and that it is especially liable to tuberculosis. The Irish race has a comparatively low deathrate among infants but a high one among adults, due to a considerable extent to tuberculosis. The Jews have a very low deathrate, and a more than usual longevity, and are less affected than other races by consumption, even though in large cities they occupy some of the most crowded tenement houses and their sanitary surroundings are far from ideal.

This low death rate among the Jews, and their immunity to consumption is observed among other nations as well as our own.

Let us notice a few facts concerning the two races having the highest and lowest death rate from consumption.

Dr. R. H. Johnson of Brunswick, Ga., a colored physician, has gathered data from a study of the vital statistics of nearly three hundred towns in the Southern States, which show that the death rate of negroes is double that of whites in the same community. He attributes this degeneracy of the race to their carelessness, want of forethought and dissipation since the civil war. In ante-bellum days the negro seemed to be immune to consumption. It was a disease almost unheard of among them. Enforced temperate living and sanitary precaution made the black man a physical giant. Then they were property and were looked after with care by their owners. They were well housed and well fed and their health carefully looked after by the plantation physician. Their emancipation gave them, in addition to physical liberty, license to induge in all the enervating and degrading vices before they had learned the necessity of self-restraint, and of regard to the laws of health.

From personal observation and from extensive inquiry among resident physicians of the South, it is found that tuberculosis exists to an alarming and excessive degree among the mulattoes. They are inferior in vitality and exhibit a much greater mortality than either the surrounding whites or negroes. In the first generation, they are fair types of health and vigor, but when their children intermarry the degeneration becomes apparent, increasingly so with each succeeding generation until the family name becomes extinct.

Ethnologists claim that human hybridity cannot be maintained without reversion to the parent stock. Dr. Robert Knox, in the "Races of Men," says: "I do not believe that any mulatto race can be maintained beyond the third or fourth generation by mulattoes merely. They must intermarry with the pure race or perish."

In striking contrast to the negroes are the Jews, tenaciously adhering to the Mosaic law and the traditions of their ancestors, rigidly maintaining purity of race, abstaining wholly from the use of the flesh of swine, "from all manner of fat of ox or of sheep or of goat," eating "no manner of blood whether it be of fowl or beast," (Levit. VII.) carefully inspecting and properly slaughtering every animal that is used for food, and presenting to us a suggestively low deathrate from consumption.

Nothing within the whole range of medicine has given the general practitioner more discouragement or heartache than tuberculosis and

nothing does he hail with greater joy than any new treatment which holds out a promise that the dread disease may be stayed or modified, if not cured.

Its curability by hygienic treatment in sanitaria has been fully demonstrated, the average results in early cases being fifty to seventy per cent. of cures, and twelve to twenty-five per cent. in more advanced cases. Naples by this means reduced her mortality ninety per cent. and England fifty per cent. New York city has 10,000 tuberculous poor, but has hospital accommodations for less than 500 consumptives, unless they be placed in the general hospitals, thereby becoming a menace to all their fellow patients. Back of the tubercle bacillus are causes which are operating to produce mal-nutrition and lowered vitality and the great object to be kept in mind in the treatment of the cases is the increasing of potential energy by means of food, air and rest.

Dr. Walters in his open air cure for consumptives at Nordrach, Baden Black Forest, Germany, has obtained wonderful results by the persistent application of nature's remedies: sunlight, abundant alimentation, continuous out-of-door life, hydrotherapy and good breathing. He holds that there can be no cure without weight-gaining and adopts a system of over-feeding. He also gives great attention to the amount of exercise, claiming that more consumptives kill themselves by doing too much than in any other way. The patient lives practically out-of-doors as windows are kept open summer and winter. The rôle which oxygen plays in the metabolism of the body is a well-known physiological fact, and he considers it of equal importance with proper food. An altitude of 1500 feet furnishes an air free from dust, and also increases the rapidity of respiration sufficiently to insure lung gymnastics.

The objection has been raised that these hospitals for consumptives would have a tendency to increase the spread of the disease in their locality. In the villages where two of the largest sanitaria are situated in Germany, Gœrbersdorf and Falkenstein, the mortality from tuberculosis has decreased among the people, being now one-third less than before their establishment. This is the very best proof that well-conducted institutions of this kind are not centres of infection.

With the wonderful development of our country comes increasing danger of infection from the foreign element which, absorbed by our people, from its lack of ordinary sanitary precautions, aids in spreading the disease. According to Vaughan's estimate for 1896 to 1899, of the 70,000,000 people living in the United States to-day, 10,000,000 will die of tuberculosis, unless something is done to prevent it. And this means an immense financial loss to the nation. Every life has a financial value, and every life saved is so much gained for the community. When a man dies of this disease it is not alone the expense of his sickness and the value of his wages that are lost to the world, but the time of those who cared for him, and the expense of the expanding influence of the disease left behind him.

The efforts of our State Boards of Health in enlightening the public concerning the communicability of tuberculosis, the prohibition of

spitting in public places, the inspection of dairies and the destruction of diseased cattle, etc., are already bearing fruit as is evidenced by an annually decreasing death rate from consumption. But much still remains to be done. The people at large cannot be made healthy by regulations enforced by officials employed for the purpose, and although there is an increasing tendency on the part of the civilized world to interfere with the liberty of the individual for the benefit of the community, in matters sanitary as well as criminal, if these attempts are made in advance of the education of the public, it may be found that "the car of progress has square wheels," and a very unpleasant though perhaps necessary jolting may result.

> **"After all these stormy changes, shall we find a changeless May ?**
> **All diseases quenched by science ; no man halt, or deaf, or blind ;**
> **Stronger ever born of weaker ; lustier body ; larger mind ?"**

DISCUSSION.

G. G. SHELTON: This paper is indisputable. I can simply utilize a few minutes in emphasizing some of the splendidly presented points. About the negro race. I think there are predisposing causes that are not found among other races. Freedom launched them into all sorts of dissipations. Syphilis is very prevalent. To what degree syphilis predisposes a patient to tuberculosis is, of course, an exceedingly interesting question. The Siwash Indian and the Esquimaux (I have had an opportunity to see these in the Yukon River country) and the North American Indian die like rats from tuberculosis. They are no sooner attacked than they are out with a flash; they seem to have no resistance. Now consider the matter of their lives, the intermarriages and venereal diseases. I believe, just as the doctor has stated, that the great security is sunshine and fresh air. In Asheville, Dr. Battle has told me that if he could have the sun shine twenty-four hours a day it would cure a very large number of his cases. The statistics, as stated from Germany, are modified by the conditions which were noticed in the Tyrol, for you find there (I have journeyed up to see them) right along the edge of perpetual snow little huts with patients living in them at an elevation of eight and nine thousand feet. These huts have their sides open. They do not mind the snow as it drifts in, but depend on the increased altitude and fresh air with its pure oxygen. The results have not been all that was hoped for and I believe it is attributed to the constant living at that altitude. That is the reason many are sending patients to lower altitudes. You can't subject a lung, especially a diseased and sensitive lung, to the constant strain of three or five thousand feet. It is terrific when you think of the atmospherical pressure. I do believe that an altitude of one thousand or fifteen hundred feet is the all-essential thing to begin with, and not constantly to strain a sensitive lung by decreasing the barometrical pressure; that is of vital importance, and that is the place where the individual can live out doors all day in the sunshine at a gradually increasing altitude, burning the bridges behind him.

One other feature, that is the mental condition. Take a man or woman, a boy or a girl, out of a home of luxury and refinement, send them off alone by themselves to fight a disease, the mortality of which is frightful—the father, mother, brothers and sisters are dead from the same disease; they face inevitable death. It seems that they are wonderfully hopeful themselves; put them in a hotel, the best room that some of these hotels have, with nothing to do; they come down in the morning, feel their pulse, take their temperature, weigh themselves day by day. Their lives are absolutely objectless. Rest, to be healthful rest, must have occupation. A neurasthenic won't get well if he goes to the edge of a lake and looks down into the water; give him something to think about and the busier the life, the harder the work, the more he will feel the result. Take these people out into the sunshine and give them something to do. I say to a patient, "Find something to do, something that will occupy your mind and make your life healthful." Let him have good society. These are very powerful elements.

There is nothing to be added that I can see—only this: Note the striking inconsistency of the Jewish race; they eschew fats and we give fats for consumption. Cod-liver oil is the essential thing of the old school, has been and probably will be. A great many people—a great many physicians—consider that antagonism to fat shows a predisposition to tuberculosis. Whether it does I don't know. I cannot explain why the Jewish race, who never eat the flesh of swine and, as has been stated in this paper, throw out fats—why they do not seem to be prone to tuberculosis. But there are a great many things in the Jewish race that I cannot explain.

When it comes to the influence of food on disease, I want to say something about tuberculosis in animals and sheep and cows. It is a subject which interests me very much and I believe in a very few years that the entire State test of the injection of tuberculin will be thrown out as unscientific, pernicious and bad. A gentleman had some Guernseys, one he paid $1300 for; he killed 12 of them, for their temperature had risen after he injected into them this poison. Another man who has made a study of the matter and whose herd is perfectly free has never given them fermented food; he claims that the bovine tuberculosis, which we fear and yet which we have not one particle of evidence influences us at all, is due to the recent or comparatively recent method of feeding the animals on fermented food, lowering their vitality, putting them in an unnatural condition, feeding them with alcoholic ferment, and putting them into close stables. I think this shows the power of food as a predisposing cause of disease.

W. L. HARTMAN: Our friend Dr. Shelton, has brought up a worthy subject here. That is syphilis. There are more people suffering to-day in the United States with syphilitic troubles than with tuberculosis—more people die indirectly in the United States, in the world—from syphilitic troubles than from tuberculosis. But do we ever say a word or do one thing to prevent syphilis? No. We lock up cases of scarlet fever, measles and small-pox, but the syphilitic, we let go to the

four winds, everywhere, without respect of persons or place! Now, if we have a healthy condition and the system has not been undermined by syphilitic troubles, are we as likely to have tuberculosis? No, we are not. Then, why don't we go to the foundation, if we are trying to wipe out tuberculosis, and try to wipe out the syphilitic first? As to the negro, we all know that there is hardly one of that race but is affected with syphilis. If you will watch these cases carefully and get the history thoroughly you will find the person who has had syphilis prior to tuberculosis drops off quickly. I have had several cases of pulmonary tuberculosis with a syphilitic history, they dropped out all at once. We have two things to fight. I believe Dr. Swett said there were some ten thousand cases of tuberculosis in the city of New York. There are every year in the city of New York something like twenty-five or thirty thousand new cases of syphilis developed. It is surprising to read "The History of Prostitution" (republished last year) the history of syphilis, as this man has gathered its statistics, and note the number of people who are affected with syphilitic troubles. When the health is undermined by syphilis, whatever the disease it is much more difficult to cure. The first time a paper has been read on that subject in the State of New York or in any other State by either school that I can find I read myself. It is one of the subjects that should be thoroughly discussed by our Bureau of Public Health. We must try to suppress syphilis as we are trying to suppress tuberculosis.

As to bovine tuberculosis, the State of Connecticut was the first that took up that subject and I believe they have dropped it; they do very little about it. They have found by repeated examinations of milk from tubercular cattle that no tubercular bacilli are found in such milk. Of a herd killed in Syracuse the cow that was the most healthy had the greatest temperature; in those most affected—nearly gone with tuberculosis—the udder was scarcely affected. If there are no tubercle bacilli in the milk, how are we going to transmit it to the human being?

J. W. LESEUR: It is interesting to know in this connection that France has just now entered upon the construction of a National Hospital for Consumptives that is supposed to be adequate to meet her needs.

SANITARIUM CARE OF CONSUMPTIVES.

HOWARD PERCY DEADY, M. D.
LIBERTY.

The question of the sanitarium treatment of consumptives is one which our school seems for some reason to have totally neglected and a department of medicine in which the allopathic profession have made great advances in the past decade; why this condition of affairs should exist seems hard to explain. In the East but one previous attempt to found a homœopathic sanitarium exclusively for this class of cases has been made and that by a physician located at Asheville, N. C., whose name I have been unable to learn. About six years ago Dr. C. G. Graham opened an institution of this kind near Denver which flourished for a few months and then, no doubt from lack of professional sympathy and support, died a natural death; at any rate no record of its present existence can be found. To what can this professional apathy be attributed?

I think we will all agree that diet and hygiene are most important essentials in the treatment of the tubercular patient and where better can these be obtained than at an institution totally under medical supervision where the smallest detail of the patient's life is regulated by the physician in charge.

At this age when microscopical pathology has been developed to such a degree of perfection that diagnosis becomes possible in many cases months prior to the appearance of any actual lung lesion, the chances for permanent cure are extremely bright if the simplest of hygienic and dietetic measures be observed. How much more then can be expected from these cases should they be allowed the advantages of a favorable climate combined with constant homœopathic treatment. As an aid to the rational treatment of consumptives, climate is invaluable. Yet, far greater to my mind would be the chances of these cases should they remain in the less desirable lowland districts but under the care of a conscientious homœopath, than that they be turned loose in some country boarding-house where air is not infrequently the chief balm to the stomach as well as to the unfortunate pulmonary member.

In deciding upon the location of a prospective sanitarium for consumptives there are many things to be considered. In the first place, in order to benefit the great mass of people, it should be located within easy distance of several large cities and this at as slight a sacrifice of climatic advantages as possible; a side mountain position with a southwestern exposure, an altitude of not less than 1000 feet above the sea level, far enough inland to escape the damp coast winds —these would seem to be the simple conditions which should be observed in the selection of a favorable sanitarium site. A plentiful

supply of good pure water is vital to an institution of this kind, therefore an exhaustive water analysis of the springs which are to supply the buildings should be made.

The building plan is an open question. Knopf, in his late work on the "Prophylaxis and Treatment of Pulmonary Tuberculosis," greatly favors the pavillion system. He is supported in this view by Dettweiler, Brehmer, Roempel, and in fact by most of the distinguished European lung specialists. On this side of the water, the cottage plan was first introduced by Trudeau at Saranac Lake. This idea was soon taken up by others, and to-day large sanitaria of this type can be found at Saranac Lake and Paul Smith's in the Adirondacks, at Citronelle, Ala., and at Liberty, N. Y.

Reports from these institutions are most flattering and the cottage system certainly has much to commend it. The opportunity for perfect disinfection in itself is a quality which should carry great weight. There can be no doubt that the expense of supporting this cottage plan of sanitarium is much greater than would be incurred in caring for a similar number of patients under the pavilion system; this fact, however should hardly be sufficient to offset the greater number of advantages obtained.

The mental condition also enters largely into the prognosis of patients afflicted with pulmonary tuberculosis and the separation of the large body into smaller parties of patients with the natural home-like cottage environment does much to produce that state of quiet contentment so conducive to physical repair.

The greater benefits derived from the cottage plan can best be shown perhaps by a brief description of the buildings. As a rule the administration, or main building occupies a central position with the amusement pavilion, chapel, infirmary and any other public buildings that there may be, grouped near by. The cottages can be found dotted here and there in favored spots within but a short walking distance of the administration building where, in fair weather, the patients eat their meals.

The administration building also serves as headquarters for the patients, and here may be found the offices of the physicians in charge, the superintendent and other officers connected with the institution. In fact the entire first floor is given over to the kitchen, dining-rooms and these aforesaid offices. The second story is devoted to sleeping rooms for the house physician and other employees of the institution.

The infirmary is simply a well equipped hospital to which the more unfortunate patients are removed should they become unfit for cottage life.

Perhaps the most interesting part of this cottage plan is the actual cottage construction. The later pattern cottages of the Saranac Lake Sanitarium serve as a type. It has been found that best results have been obtained with cottages accommodating but from four to ten patients with a preference for the smaller number. The cottages are usually but one story high and consist of a large reception room with bed chambers off it. The whole front of the reception room opens

upon a broad veranda where the patients are expected to spend the major portion of each day.

Perfect ventilation is obtained in a most ingenious manner; the partitions between the chambers and reception room extend to within but two feet of the ceiling and this, in connection with a large transom over the outer door of the reception room, supplies a constantly changing circulation of pure air to every room.

The partitions between the different sleeping rooms are of entirely different construction, consisting of a double wall with a small air space between which under ordinary circumstances completely deadens sound. These partitions extend to the ceiling. The interior is finished in Georgia pine including the walls and ceiling. This permits of frequent and thorough disinfection which in no wise defaces the property. Most of those cottages are heated in cold weather by a large open fire place in the reception room. In all other respects the construction does not differ materially from other well built sanitary cottages.

The sanitarium treatment of consumptives is always a problem and no cut and dried regime can be laid out for every patient. General physical condition, temperament, mental condition and many other important elements enter into the question and nearly every case must be approached differently.

It has become a habit with me upon receiving a patient at the Liberty Homœopathic Sanitarium for Consumptives, to first indulge in a long informal chat upon the subject of his illness, his future plans, etc. Of course this is necessary to a certain extent in order to ascertain the history of the case for a guide in treatment, yet it is just as important to my mind, to gain the patient's confidence and friendship if possible, and it is to this end I strive. The average consumptive will not do well should he be at odds or even lukewarm in his relations with his medical advisor.

Having become possessed of all that can be gleaned from the patient's talk concerning his history, a thorough and extensive physical examination should be performed. This applies not simply to an examination of the lungs but should include the larynx, heart, spleen and urine as well. A complicating tubercular nephritis for instance would materially alter the commonly prescribed diet. A malarial spleen might in part account for an unusually high temperature, etc. In fact it is most essential to know as nearly as possible in just what condition your patient's different organs are in order to intelligently treat the existing lung lesion.

The sanitarium rules and regulations are read to every patient upon entrance and the object of these rules explained. I have yet to meet the first objection or intentional disobedience to these regulations which every patient is taught are formulated and enforced for the safety of himself as well as all others concerned.

To most of the laity, anticipation of life in a sanitarium for consumptives possesses few charms, if not productive of absolute abhorrence, and it is most important that this introduction be made as pleasant

as possible if any headway from a curative standpoint is to be expected.

At an early date, a specimen of the sputum should be examined under the microscope and a record of the findings kept for future reference. It is also a good plan to make further examinations from time to time, though too much importance should not be given these results, for not infrequently sputum examinations will prove unsatisfactory even when the patient is apparently improving in every other respect, and vice versa.

Hygiene, dietetics and medicine are the most generally accepted adjuncts to the climatic treatment of pulmonary tuberculosis. The hygienic treatment is by far the most essential and also the simplest in execution if a few common sense rules can be kept in mind.

The consumptives first of all must be appropriately clothed and this does not mean that he should be loaded down with wearing apparel. Wool should be worn next to the skin at all times; the weight depending upon the season. Even during the more severe winter weather, quality rather than quantity should be considered. The feet must be properly clad and kept warm and dry at any cost. Garments so constructed as to embarrass respiration to the smallest degree, must be tabooed; no part of the body in fact should be subjected to the slightest restriction. The patient must sleep under conditions of perfect ventilation. He must not be in a draught, yet a temperature of from 45° to 50° is not too low for the sleeping room if a sufficiency of covering be provided.

From seven to ten hours daily in the open air is the usual time limit prescribed for these patients. During the winter months it may become necessary to reduce this somewhat, yet the crisp winter weather is favored in this climate and full advantage of this season must be taken. Lung gymnastics play a most important role in the hygienic treatment of all patients possessing a weakened respiratory tract. A salubrious atmosphere compels to a certain degree an increased pulmonary action and this to my mind, is one of the chief benefits of climate.

In incipient cases when febrile symptoms were absent or have been controlled by treatment, it has been my custom to introduce a simple form of chest exercise with the view of increasing lung expansion. If after a time no reaction sets in, this exercise is followed by a sponge bath with tepid to cold water. Discrimination must be shown in the selection of cases for this rather heroic treatment and the after results carefully noted. The experiment will usually prove most invigorating and beneficial or decidedly the reverse, in which event the operation must not be repeated for a time at least.

The fever symptoms as indicative of inflammatory progress must regulate the amount of activity allowed a tubercular patient. For cases running a daily maximum temperature of 100° or more, I have observed very marked benefit from the modified rest treatment introduced by Dr. Knopf. The so-called rest cure simply consists in keeping the patient constantly in a reclining position and out in the open air as much as possible. For three or four hours at a time he is

expected to lie perfectly quiet and make not the slightest mental or physical effort. To accumulate strength which will lessen the rapid cardiac action and thereby reduce the fever, is the object of this complete relaxation and in many cases the treatment works like a charm.

The rest cure is extensively used in the majority of the European sanitaria and was originated by the famous Dr. Dettweiler, the aged director of the Falkenstein Sanitarium, which is the oldest institution of its kind in the world.

Dr. Knopf, while not in any way deprecating the benefits of the rest cure, claims that the introduction of very light exercise, as for instance lifting the arms above the head while breathing deeply and executing this diversion at intervals of about two hours, will lessen the chances of catching cold and of a possible hypostatic lung complication, as well as greatly hasten recuperation. During the past three months I have placed eleven cases under this modified rest treatment: Of these, seven showed great improvement, two have about held their own, one has since died and the other is near his end.

Tuberculosis is primarily a wasting disease and this fact must always be kept in mind when prescribing the diet. It will not suffice to simply satisfy the normal appetite of the phthisic. He must be tempted with appetizing dishes and constantly urged to consume as much nourishing food each day as possible. The meals should be at regular hours with dinner in the middle of the day. Midway between each meal I have found some light repast, such as the whites of two eggs beaten in a glass of milk and cream, most sustaining and yet not sufficiently heavy to embarrass the appetite for the coming meal. This egg and milk combination is also taken at the end of each meal and if possible just before retiring. By this means the patient consumes from eight to twelve eggs daily with little or none of the usual accompanying disagreeable sensations, in addition to the large quantities of milk and cream. Koumyss has also proved valuable and in bad cases can often be retained when nothing else will stay on the stomach.

Stimulants have their place and when indicated are invaluable. Under ordinary circumstances however, they should never be prescribed for incipient cases. When the patient is weak and apparently losing ground the temptation to resort to stimulants is strong, particularly when your methods are constantly criticized by his many friends and advisors. The carefully selected homœopathic remedy however, will usually clear the atmosphere and the dangers of stimulative reaction obviated.

What homœopathy has done in the past to alleviate the many ailments to which man is heir she will ever continue to do in the future and, all things being equal, the day cannot be far distant when the consumptives will learn to love and revere the memory of Hahnemann in the same spirit as do his many staunch followers of the present.

DISCUSSION.

E. H. PORTER: There is one point not touched upon in this paper that I would like to bring before you. A bill, brought before the Legislature for the establishment of a State Sanitarium for Consumptives to be located in the Adirondacks, was killed in committee on the plea, first, that taxation must be kept down and, second, that a convention of skilled experts in tuberculosis was about to be held in Berlin and that the Finance Committee would like to know their conclusions before that committee would consider this enterprise. The conclusions of the commission at Berlin are briefly these: First, that consumption is not inherited, but that the tendency is. Second, that more cures are effected at sanitaria under the present system of treatment, more cures effected in the inception of phthisis, than in any other manner. Third, that the Commission recommends the establishment of State sanitaria as fast as possible.

This report of the Commission seems to dissipate the second objection. So far as the first objection is concerned, it certainly seems to us who have considered the matter that (according to the latest and most approved scientific opinion) by reason of the death of efficient members of the State owing to the ravages of this disease, when upon computation it is found that ninety millions dollars annually are lost in the State of New York by devastation in deaths, it seems that the State might venture two hundred thousand dollars to establish a sanitarium in the Adirondacks. This bill never got outside of the Finance Committee.

Conferences have been held with a view to re-introduce this bill next winter at Albany. It certainly seems to me that it is unnecessary to outline an argument for the establishment of a State Sanitarium. It has passed the experimental stage; we know the work and are familiar with the results. This Society should go on record now as in favor of that proposed bill.

REPORT

OF THE

BUREAU OF OBSTETRICS.

"A Clinical Experience in Puerperal Eclampsia," - J. WILLIS CANDEE.
"Albuminuria of Pregnancy," - - - JULIA F. HAYWOOD.
"The Use of the Fillet in Breech Cases," - - GEORGE R. STEARNS.

A CLINICAL EXPERIENCE IN PUERPERAL ECLAMPSIA.

J. WILLIS CANDEE, M. D.
SYRACUSE.

Between ten and eleven o'clock one forenoon, a few months since, I was hastily summoned to consult with Dr. X. in a maternity case. Arriving at the house, was informed that the patient had a convulsion about fifteen minutes before.

The following history was quickly given: Primipara, aged 27, of extremely sensitive nervous organization, had suffered from a spinal trouble (exact nature not stated), had always a weak and irritable heart with proneness to "sinking spells" but no valvular murmur, no history of pre-existing renal disease, was subject to severe headaches from which during pregnancy she had been almost entirely exempt, bowels always normal. Gestation had continued two weeks or more beyond the calculated time. She had throughout been carefully watched by her physician. Urine was first examined at beginning of fourth month. During the last three months analyses were made about every fortnight. In these examinations attention was given to total solids and urea excreted. The solids were sufficient, excepting for short periods at two different times, when they quickly reurned to a satisfactory amount. Two weeks before confinement slight albuminura was detected, with however no subjective symptoms. Four days afterward there was slight œdema and deficiency of urinary solids. Under treatment and dieting, œdema quickly disappeared as did also the shortage of solids. During the last week the quantity of urine was noticeably increased (5 pints). The absence of suggestive subjective symptoms continued until labor began. On the day preceding her sickness she had been as well as usual. Slight pains were felt in the evening, becoming more marked about 11 p. m., but continuing rather

moderate throughout the night. Towards morning she complained of hemicrania and appeared slightly dull. Urine was voided three or four times during the night and early morning. After the postman's morning visit she had looked over her mail.

On my arrival found the patient with countenance somewhat suffused, the face having an unnatural expression, although she recognized every one and would answer questions, the sensorium was dull and she did not pay much attention to occurrences about her.

Examination showed a normal presentation with but slight dilatation of the os. Labor pains were inefficient. I advised artificial dilatation and delivery as rapidly as possible. Expecting a serious time, also took measures to secure the wise counsel and assistance of our worthy President. Meanwhile the work of dilating had been begun. This I undertook by an adaptation of the method described by Dr. L. L. Danforth in a paper read before this Society in February, 1898. Permit me to remark that had I not chanced to have heard Dr. Danforth's explanation, being present at the time, it is doubtful if I should have possessed this bit of professional knowledge ready for immediate use. In this can be recognized a difference between hearing a paper and its discussion at a society meeting, and "just as well reading it in the Transactions."

The method referred to consists in getting through the os first the index finger, then the thumb (both extended), using the index finger at first as a guide for the thumb. When both are admitted flex, and either withdraw them while flexed, or use them within, by alternate flexions and extensions carefully causing the parts to yield. As soon as possible add the next finger to this wedge, and continue until the whole hand may be used in like manner. By judicious application of this method, including rotation, the operator's fingers and hand constitute an ever-ready adjustable and sensitive dilator. In the case in question results were prompt. Before Dr. Sheldon arrived, a sufficient degree of dilation had been obtained. As pains were then coming rapidly and with force, there had been no recurrence of convulsions and the patient's condition seemed to be improved, manipulation was suspended, the sac ruptured and the head permitted to descend, in the hope that labor would proceed satisfactorily. As soon as matters were allowed to progress naturally, the head settling well into the pelvis, a second convulsion occurred. I then applied forceps with the expectation of making a very rapid delivery. Catheterization obtained a few ounces of urine, the quantity of which was not measured. Instead of a rapid forceps delivery, this proved to be one of the most tedious in my experience. The obstacle appeared to be a thick unexpanded lower segment of the uterus which closely hugged the presenting part and blades of forceps, descended with them, and would not yield to mechanical efforts although willing to sacrifice, if need be, cervix and perineum for the sake of time, I dared not use force which, if exerted beyond certain bounds, promised to do serious mischief. This state of affairs resisted all attempts at speed and it was upwards of two hours after the application of forceps before delivery was affected.

Throughout this time there were no convulsions, so towards the close of the second stage a successful attempt was made to save the perineum. To our surprise the child, a boy, was born living and unharmed. Placenta was promptly delivered. By catheter, about three ounces of dark, smoky looking urine was obtained, which specimen was unfortunately lost. During part of the period of instrumentation, more or less anæthesia was produced by chloroform. Shortly after the completion of the post-partum toilet, came the third convulsion. This marked the beginning of a series of paroxysms recurring at first at long intervals, then increasing in frequency and severity till the end, with no special features to be described. Early in the following evening, eleven ounces of urine were taken by catheter and examined. Its reaction was acid, specific gravity 1016, of smoky appearance, highly albuminous, continuing blood corpuscles, broad epithelial casts and blood casts. The patient died at 2:30 a. m. Additional counsel was called but nothing availed. As to treatment that was along the usual lines with nothing particularly instructive to be noted.

Reasons for bringing this case to your attention follow: It is unlikely, I fancy, that we more than Dr. X. would have expected such a termination of this pregnancy. An interesting fact in this connection is the experience of the patient's sister, who had shortly before, by the same physician, been safely conducted through an apparently perilous pregnancy. This lady developed a high degree of albuminuria and œdema, and her condition for a considerable time towards the close of gestation had been the cause of great anxiety.

Occurring, as did our case, in a woman who had been closely and skillfully attended throughout, and who to the last continued singularly free from what we understand to be danger-signals, we must cast about for reasons. Two closely related questions occur. First, were the methods of urine analysis inaccurate, and second, may an unrecognized lesion of the kidneys have pre-existed and formed a basis for the acute nephritis? I understand that the total solids were computed by means of Häser's co-efficient, which we regard as a suitable method from samples of the total twenty-four-hours' collection. Urea was estimated by the ureometer, the accuracy of which may be questioned. The matter of previous unsoundness of kidneys cannot, of course, be satisfactorily considered in a closely critical sense. I am inclined to conclude that either the fatal toxemia was not recognizable at its inception, or was developed with astonishing rapidity.

Whether the uncommon amount of trouble with the unexpanded lower segment of uterus is or is not chargeable to artificial dilatation is a question of which I have thought. It is easy to understand that opening the os is not a perfect counterpart of nature's first stage of labor.

Another noticeable point was freedom from convulsions during the enforced portions of her labor, for which the use of chloroform would scarcely account.

DISCUSSION.

M. BESEMER: The Doctor gives a history of an interesting case, such as obstetricians frequently meet in a large majority of cases, the result of these puerperal convulsions due to acute nephritis, is uræmic coma and death. The mechanical treatment is all right, but he hasn't said anything about remedies. I am a sort of a medicine man myself and I haven't heard anything about medicine since I have been in Binghamton. It would be well to go over the remedies that prove efficient, such as veratrum, gelsemium, belladonna, cicuta, hyos. and (hypodermatically) pilocarpin. Have you any remembrance of the remedies given at the time?

DR. CANDEE: Not a clear recollection.

DR. BESEMER: My usual treatment has been to hold the convulsions down as much as possible with chloroform and if there is any suppression of urine to apply hot fomentations over the kidneys, perhaps some turpentine, hot flannels to wrap up the body; pilocarpin (hypodermatically) relieves the kidneys by causing profuse perspiration and in cases in which the convulsions frequently recur I have held them by using enemas of bromide of potassium and chloral hydrate. That is probably not strict homœopathy. Then, of course, there are a great many remedies. I have never had any very brilliant success with remedies in potencies for these convulsions, but I think I have had better results with enemas, fomentations and sweating than with any remedy given homœopathically, except perhaps veratrum one drop doses.

JOHN L. MOFFAT: Although physicians first we still are homœopaths and the principal object of these meetings is to confer about the application of homœopathy. Has any one here been able to cure these cases homœopathically? Homœopathic remedies have cured such cases according to our books. We would like to have some testimony, some help, some encouragement to go on trusting in homœopathy when we come together as homœopathists.

One thing has not been mentioned, that is, the giving of our homœopathic remedies hypodermatically for convulsions. In case of severe puerperal convulsions, hyoscyamus seemed to be clearly indicated; I dissolved some small pellets medicated with the tincture in a glass of water and gave drachm doses hypodermatically with perfect success. A child in convulsions with unconsciousness for three hours despite ordinary treatment, received cicuta, as above, hypodermatically. We all know that the homœopathic remedy will act in desperate cases. A patient pronounced dying (by two doctors in consultation) responded to carbo. veg. 200 and lived a week after. It could not have been anything but the carbo. veg. which so stimulated him. And I know that the homœopathic remedy will cure convulsions.

DR. BESEMER: I have had a large experience in maternity cases and have encountered a good many of these cases and they did not all die, but I must own up that in giving the potencies belladonna, hyoscyamus, gelsemium, cicuta, etc., I never got as good results. I

branched off on general principles and the patients didn't die. I believe in homœopathy and practice it pretty fairly.

E. W. BRYAN: It has been my misfortune to meet a few of these cases and my good fortune to see them all recover; I have never used anything but homœopathic remedies, except the application of heat. Hyoscyamus, cann. sat., gelsemium have been used as indicated.

DR. CANDEE: The chief idea in bringing this subject again before the Society is its never-failing importance, and the fact that our relations—either homœopathic or old school—are not satisfactory with this form of illness, as we all realize.

F. PARK LEWIS: We are dealing with a toxin that is expending its force on the central nervous system, one produced by mechanical causes, the blood being surcharged with it; the agent which will get rid of that poison will save the brain. I wonder if normal salt solution by transfusion will not be a valuable help—a quart or perhaps two—to dilute the blood so as to carry off the poison.

DR. CANDEE: A practical suggestion. In closing the discussion I would say in reply to Dr. Besemer, that I cannot accurately give him the treatment which I used. Will say that these remedies I know were used: gelsemium, aconite, veratrum viride (apparently some satisfactory results for a time with the latter in appreciable doses). Cuprum ars. was also given; the results from that were not at all satsfactory. Later when the case was progressing unfavorably, rectal enemas of chloral hydrate and bromide of potassium were used. Chloroform, of course, to control convulsions. There was some difficulty found in using depressant means from the fact that the patient's heart was very readily affected. The suggestion offered by Dr. Lewis I consider very timely. I think we will all feel disposed to try it. Saline solution is coming into vogue as a means of increasing elimination through the kidneys and as a means of escape from some of the gravest conditions that the practitioner, whether medical or surgical, has to meet.

ALBUMINURIA OF PREGNANCY.

JULIA F. HAYWOOD, M. D.
ROCHESTER.

This disease of pregnancy has long claimed the notice of obstetricians. Its cause, frequency and treatment will continue to claim attention as long as the pregnant woman is subject to conditions which pervert the course of a healthful and natural parturition. Authorities differ greatly as to the frequency of albuminuria, one stating that twenty per cent. of pregnant women are thus affected, while another from statistics collected from private sources states that only one out of three hundred had albumin in the urine. These last figures can scarcely be termed official, as it is to be feared that many physicians

neglect to examine the urine of pregnant women, while many more have no opportunity of so doing. However, the disorder exists and numerous theories are broached as to the cause. The albumin as a rule disappears with the termination of the pregnancy, so it must be conceded that the pregnant state predisposes to this condition. The pressure of the gravid uterus causes venous congestion, interfering with the elimination of the secretions from the kidneys, and thus acts as a cause. Another cause might be an excess of albumin in the blood, and any condition, such as exposure to cold or impeded cutaneous action, could be attended by altered condition of urinary secretion. Other interesting attributes of the urine in non-pregnant and pregnant women have been demonstrated by a series of elaborate experiments. A toxic element is present in all urine; this toxic principle is augmented during pregnancy and much increased during the last months and weeks. It is estimated that poison enough is generated in forty-eight hours to cause the death of the person if any failure to eliminate the toxic element should occur. The poison is also found in the blood of an eclampsic person, and always greater in the urine and less in the blood after an eclampsic seizure. By these experiments there would seem to be a direct connection between the condition of the urine and puerperal convulsions, and the conclusion is also reached that the danger is greater as the secretion of urine is lessened. Another experiment was upon a guinea pig after an induction of a substance answering to all the tests of paraxanthin. This substance caused a set of symptoms corresponding so nearly to the symptoms produced by the injections of boiled urine that the conclusion was reached that the poisons were identical. If so, an important deduction is reached, namely, to interdict the use of any substance, particularly meats, liable to cause or develop ptomaine poisoning. The diet of the pregnant woman is a matter of much importance, aside from a tendency to albuminuria. The parturition may be made safer and easier if the development of the child is somewhat restricted by eliminating such foods as tend to produce bony and adipose tissue in excess. A selected diet to produce a desired sex is a matter still of experiment and doubt, but that the selected diet can secure for the pregnant woman a safer parturition is a matter of fact. Attention should be paid to the quantity of urea excreted and when the percentage falls below 12 grs. to the ounce, active measures should be taken to increase this amount. Frequent bathing, diuretics, sweating, free evacuations from the bowels, all these are a means to that end. It is always my practice to test at frequent intervals the urine of all pregnant women who place themselves under my care. I have never found albumin before the fifth month and not many times after.

Mrs. B. brought some of her urine at the end of the fifth month, exclaiming at the uselessness of testing when three previous pregnancies failed to develop any albumin; testing revealed albumin in large quantities. I prescribed arsen 6^x, suggested care in diet and told her to come again in two weeks. Five weeks passed and I sent a message to call at my office. She came, displeased at my urgency,

and said she was perfectly well and getting stout. I saw at a glance the pronounced œdematous condition—all the tissues dropsical. On testing found the albumin increased. I put her on strict diet of skimmed milk, with merc. cor. 6^x; her stoutness disappeared and the albumin diminished. She had to continue the strict dieting until the termination of pregnancy, but had a normal and short confinement. Previous confinements had been instrumental. The day before she was confined a friend and neighbor died in puerperal convulsions. As a consequence, Mrs. B. was more than grateful for the care that possibly saved her from a similar fate.

Mrs. C. developed albumin to a slight degree during the sixth month. The amount was never large, but shortly before her confinement occurred she had a heavy chill. This seemed to mark the death of the child, as no further fœtal movements could be felt. During the last stage of a severe labor Mrs. C. became delirious and had several slight spasms. The child was born dead and the mother rallied, but the next morning suddenly, without warning, had one single convulsion. No other followed and she made a slow recovery and all albumin soon disappeared, as it did in the former case.

Mrs. L. developed albumin in large quantities, which was limited in amount only by strict dieting. Any return to ordinary diet would cause a large increase of albumin. The delivery was uneventful. No albumin at present three months later, and no convulsions at any time.

These cases all occurred in the last few months. Another case had violent convulsions on the fourth day following a confinement for which I had not been engaged. During the convulsions, which were one sided only, the convulsions could be increased in violence, and could also be induced, by pressure upon the left kidney. No albumin was detected at all in this case. Diet certainly plays the most important part in the treatment of this disease, and the history of these cases and others I have had would show that by proper oversight and treatment, the fatal element should be largely eliminated. When convulsions ensue pilocarpin hypodermatically will ease the overburdened kidneys. Chloroform and verat. vir. control the convulsions. Let me urge again the importance of testing for albumin, that our records as obstetricians may be free from the reproach of any death from such an omission. Merc. cor. 6x and ars. 3x as internal remedies meet the requirements of most cases. The diet has been principally of skimmed milk and fruit.

THE USE OF THE FILLET IN BREACH CASES.

GEORGE R. STEARNS, M. D.
BUFFALO.

Apologizing in advance for the simplicity of the case here presented, I submit the following history: Mrs. W., aged 28, the mother of one child, born some two years previously, was confined on the evening of August 28th last, at about full term. Her former confinement had been normal and uneventful, the presentation being left occipito-anterior. On reaching her bedside, in response to a hurry call, I found that the labor had come on suddenly with the breaking of the waters, the os was dilating rapidly, a breach was already well engaged in the superior strait, presenting left sacro-anteriorly. A more thorough examination during the period of relaxation disclosed a loop of the cord which had slipped out, in all probability, with the sudden escape of the waters before the presenting part had sufficiently closed the uterine outlet. During relaxation pulsation could be felt, distinct but becoming weaker; but during the pressure incident to the pains, which were frequent, regular and strong, the pulsation ceased entirely.

The case was one evidently calling for prompt and decisive action if the life of the child were to be preserved. The body had already descended too far to allow the cord being passed back into the uterine cavity out of danger from pressure, and hence rapid delivery was the only recourse.

I immediately placed the patient under chloroform to a sufficient degree to permit my dilating the vulva and vaginal outlet with the hand (rendered aseptic and thoroughly lubricated with vaseline) and preparing the perineum to allow the rapid passage of the body and head without danger of rupture. The pains, though still strong and regular, were not bringing the labor on with a rapidity consistent with the safety of the child and I decided that the fillet would give me better assistance under the circumstances than either the forceps or the blunt hook. Taking a strip of sterilized roller bandage three inches wide and a yard long, I lubricated it thoroughly and rolling about one-third of it into a wad, passed it up alongside the presenting breach, tucking it in between the right thigh and the abdomen of the child, intending to pass it across both groins and bring it out on the other side. Finding however that the position of the protruding cord would prevent this manœuvre I reached up between the thighs and brought it out then, thus forming a loop which embraced within its fold the right groin and hip of the child. Having thus secured a good, firm purchase, with no danger of injury to the soft parts of either mother or child, the perineum and vaginal outlet being already well dilated by my hand, I was enabled to complete the delivery in a very few minutes and with my finger in the child's mouth swept the head out without breaking even the fourchettes. The fœtal heart was still

pulsating and it did not take long to establish a good, vigorous respiration.

The detailed recital of this case, presenting so little out of the ordinary, has appeared to me to be warrantable only as emphasizing two facts: the first being the advisability (or rather the necessity) of making a thorough, high-up examination during the period of relaxation between the pains in cases like the above when, on finding labor more or less advanced, a mere cursory examination will suffice to discover the presentation and position, whereas failure to recognize the protruding cord and the call for corresponding haste in delivery would undoubtedly result in another of those unfortunate cases of failure to establish respiration through a "Dispensation of Providence"(!)

The second point is the ease and simplicity with which the fillet may sometimes be applied, without the bougie catheter so generally advised, with advantages in the way of both safety and efficiency over either the forceps or the blunt hook, whenever for any reason rapidity of delivery is required.

REPORT

OF THE

BUREAU OF MATERIA MEDICA.

"The Study of Materia Medica the Safeguard of Homœopathy," - - - - - - GEORGE G. SHELTON.
"Verbascum thapsus," - - - - - - W. A. DEWEY.

THE STUDY OF MATERIA MEDICA THE SAFEGUARD OF HOMŒOPATHY.

GEO. G. SHELTON, M. D.
NEW YORK.

When our judgment is influenced by our sympathy, we are apt to be venturesome. It was sympathy in part that suggested the title to this brief paper together with a strong desire to arouse more interest in the subject. My sympathy was for the Chairman of the Bureau, a sympathy born of experience, for I have served at several different times on various bureaus of materia medica, and I believe it to be the most difficult task involved in one's loyal membership to this or its kindred organizations.

This paper will not present a new discovery in homœopathy, or con-

tribute directly to our knowledge of drugs. It is solely in the nature of an appeal. Bear with me then if I briefly rehearse a few trite facts that may possibly have escaped the memory of some of my hearers.

Homœopathy is not pathology, or surgery, or bacteriology, or any specialty. It is clearly identified with each, but it is a department of medicine distinct by itself. It is a scientific method of prescribing drugs only, and to this department of the medical science is alone due its birth. This alone makes us a distinctive school and to the results obtained from the use of such remedies under our distinctive law, we, as a school, must survive or perish.

These, I am sure you will grant, are proximate principles fundamental to our existence and of primary importance, that is, if we are to continue as a sectarian or special school of medicine.

Why, then, is it true—and I challenge any man to dispute my statement—that it is almost impossible to arouse sufficient interest in this subject to gain enough contributions to fill in the allotted time of the Bureau? Why is it difficult to get a chairman for this bureau? And when one self-sacrificing member will undertake the thankless task, why is it necessary for him to spend the intervening six months of time in vain appeals for contributions?

Throw for a moment science to the dogs. Disregard all of the noble sentiments that we love to express, forget the spirit that dominated our forefathers and approach the subject from a purely selfish standpoint, that is, the pecuniary one. Sordid as it may be to get down to that level, would you not think that men would carefully protect the very principle that gives them bread and butter, and jealously guard and strive to protect a system that has proved so successful from this standpoint? I do not wish to tarry upon this plane a moment longer than is necessary, but use the illustration solely for the purpose of presenting to you what may seem to be an extreme view and to urge you to consider with me some possible solution of the problem that confronts us. I also wish to make a suggestion that will, I hope, at least elicit a discussion upon this very important matter. I know it is a subject upon which men may reasonably differ but upon its ultimate solution depends our survival as a school of medicine, and my solicitude on this score may have made me pessimistic on that important point.

I cannot avoid this feeling when I look forward to what homœopathy must do to maintain its position, and almost hopelessly despair when I realize how little it is doing in advancing the work of its founder and his immediate followers. I share equally the pride of every member of this Society in the brilliant achievements of all the specialists in our school. I am proud, as you are, of their surgical triumphs and their pathological researches and in no way would I suggest limiting the work in any of these departments. But I wish to ask that you join with me in an endeavor to increase the interest at least, and the co-operation if possible, of every member of our school in this almost tabooed and unpopular subject.

To attain this end it will not be necessary to change our form of business procedure or to appoint any special committees, or to do any-

thing different from what we have been doing other than this, that each member of the society, be he surgeon, oculist, bacteriologist, or interested in any other department, give this matter the careful thought and consideration to which it is entitled, and resolve that he will do something, in some way and at some time during the next year, be it ever so meagre, that will aid in attaining the desired end.

So long as we have a sectarian name at the head of our society and on all of its literature, we must keep materia medica at the front. It must never be allowed to become subordinate to any other department of work. Its consideration must be the most important work we have in our meetings.

I do not believe there is a physician of our school who does not in his daily practice have some experience, confirm some symptom, obtain some result that, if he would note down at the time, could be contributed and become most valuable to the rest of his associates, and in itself form the nucleus for a discussion, brief but of lasting benefit to all who listen to it. I cannot feel that any member of this society can shrink from the responsibility that he owes to his fellow members in aiding in the verification of our materia medica, and it is only in such a way that we can ever bring it to perfection.

Suppose every physician would simply make a note of some such experience or result, and we could so adjust our bureau of materia medica that instead of occupying our time with papers such as this, which I frankly claim should have no place or time in its deliberations, we could have twenty or more brief confirmations or short verifications of results, surprising oftentimes in themselves; in other words, if we could turn our bureau into what in olden times at religious gatherings was called an "experience meeting," much good could be obtained.

As in several instances reference has been made to the specialists, they may feel that their work is of less value than others in this society. On the contrary, their contributions would exceed in their scientific worth those from any other source. Confirmations of symptoms on the organs of special sense, or those that are met with in connection with surgical work, or those that prove the harmony that must and does exist between the pathological and the symptomatic, are the very foundation stones of a broad, far-reaching study of our law.

It may be possible that as a teacher of this subject I have an exaggerated impression of the lack of interest often manifested on the part of students at the beginning of their medical course. They come to us full of ambition and desirous of attaining as near a perfect standard as possible, but the subject of materia medica is not the one that attracts them to a medical life. The amphitheatre with its glittering paraphernalia is their first inquiry and their lasting impression. This is not a fault, perhaps, but an omission and comes primarily from their home training, and when I speak of home training from a medical standpoint, I mean the influence of the preceptor over his student—this influence shapes that future doctor's career. The conversations they hear, the cases that are recited in their presence when away from

the college are other than those relating to materia medica. The diseases that depend upon medical action for their cure are commonplace. Typhoid fevers and pneumonias at one extreme, and a cold in the head or a teething baby at the other are regarded as puerile, rarely discussed, the cure of which is looked upon not as a triumph of the medical art, but as a fortunate excursion through a well-beaten road.

Dr. Dunham made the statement that "the proper interpretation of human symptoms was the greatest effort of which the human mind was capable" and this was not far from correct. Certainly such opportunities for human endeavor should stimulate our greatest efforts.

I have thrown out these few suggestions in the hope that the successor to the present able incumbent of this Bureau will have an easier task than fell to me and I believe has fallen to him, but more than all that we may secure a lasting and enduring place for our school.

DISCUSSION.

W. H. PROCTOR: I am very much impressed with the value of this paper and exceedingly interested in it, and especially in the proposition of the experience meeting. It has been said that the time of these meetings is largely occupied by special work in which the general practitioner is not particularly interested; for this reason many have not joined the Society. While this may be doubted, it is evident that we are neglecting the study and reports in materia medica, and it seems to me that this experience meeting, properly conducted, is just the thing to put new life into this study. Speaking as one who has studied the allopathic system I wish to say that although our system is not yet perfected it is by far the best system that has ever been discovered. (Applause.)

My experience has not been confined to the treatment of others alone but in personal sickness I have obtained quick and permanent relief, which I am sure could not have been obtained from the remedies of any other school. As time goes by I am more and more impressed with the thought that we must adopt some radical measure to bring out the latent interest in our great heritage, the homœopathic materia medica.

DR. LE SEUR: The importance of this paper cannot be overestimated. We all agree with Dr. Shelton in the wisdom of cultivating the acquaintance of the specialist; we need him as he needs us who are in general practice. There is a reciprocity of interests there which increases with the intelligence of physicians in general practice and the acumen and skill of the specialist increases in a direct ratio, but we lose sight of a most significant and important fact in this Society if we fail to appreciate the value of that vital principle which distinguishes us from other schools of practice and which makes for us large advancement, and we shall fail to achieve that which is best as a society and as individuals if we lose sight of the importance of the study of the materia medica. We shall have achieved an object well worthy of our attendance at this meeting, even assuming that we

gain nothing more, if we carry home with us and make practical and personal the admirable suggestions in this paper and so arrange our work as a society that it shall become true in the not far distant future that an experience meeting of a couple of hours shall be held, in which a roll shall be called of the members—a roll which, we believe, should be largely increased—and when that roll shall be called each member responding to his name shall, in a period of time perhaps not exceeding five minutes, tell the Society that remedy which he has found most useful during the year or the result of that treatment which he finds is most satisfactory along the line of homœopathic practice.

W. L. HARTMAN: I was told this morning when I entered the hall that I would have to keep still, for the surgeons, the specialists, had no business to talk in this session. Dr. Shelton speaks of the paraphernalia of the amphitheatre which glitters in the students' eyes. Possibly we may go back to the college, from the class in which we graduated and find some fault. When I returned from college my faith in homœopathy was not of the best, simply on account of one of my teachers in materia medica. There are several in the room who, if I should mention the gentleman's name, would say, "Amen!" He had only four remedies which he prescribed: calcarea carb., podophyllum, lycopodium and nux vomica. He did not, to my mind, cure his cases. I saw no results from homœopathic prescriptions until I tried for myself in practice; then I was thoroughly convinced of the efficacy of the higher attenuations. Up until that time my faith was not so very strong in homœopathy—we might as well consider this an "experience meeting" and begin right here as well as anywhere else. I was called out one evening about eleven or twelve years ago to see a lady who had never employed a homœopathic physician before. She was suffering with asthma; sitting with feet in the oven, face over the stove and so exhausted that she could not give me her symptoms. All that I could get were a few symptoms from the family. She had suffered from these attacks for about ten years; had one about once a month and they would last for a week to ten days; this was the third day of the present attack; she had not been able to lie down or sleep even in her chair during this time; you could hear her breathe before you got into the room. I had a pocket case with me and some way or other I had some arsenicum[60]. I thought it was a clear-cut case for arsenic, so I left three powders, saying to the woman with a great deal of assurance: "Take one of these powders; if no better in an hour, take a second; if not able to lie down and sleep in two hours, take the third, and you will be all right." I walked away and I said to myself: "You are one of the best bluffers I know of." The next morning I called at the house between eight and nine and met the lady at the door; she was up and around. She said to me: "I never had anything relieve me in my life like that. I took the first powder and was able to get up and walk around in an hour's time; then I took the second powder, and in an hour and a half I was in my bed and asleep." She had an attack a month after that and I tried the third attenuation and it aggravated. I then prescribed the 200th, which relieved her promptly. She only had the attack two or three days,

but I did not cure my case with ars. alb. I found the remedy was sepia; I gave her one prescription of sepia[200] and she for five years never had another attack. The only sepia symptoms I had to prescribe on were very fine copper spots on one cheek.

JOHN L. MOFFAT: We are all specialists—a specialist is not necessarily an exclusivist. The specialists in surgery have surgical societies; those in the eye ophthalmological societies, and we specialists in homœopathy homœopathic societies. The oculists meet and talk ophthalmology, the surgeons surgery—practically and in detail. We come here as homœopathists, but how much homœopathy do we learn? But we are not only homœopathists, we are doctors and must keep abreast with the times. It is one of our tasks to reconcile homœopathy and pathology that the latter may help make the former more easy to understand and apply.

But there is no doubt we ought to have a revolution—just the change which Dr. Shelton suggests. We are all guilty, one no more than the other; we know we are guilty and vow we will do better, but we don't.

Next year is our jubilee—fifty years of our Society—and from the point of view of the Materia Medica Bureau the Society has been running down for fifty years. Now, can't we have a jubilee next year in materia medica and introduce experience meetings to stay? There are two ways of studying materia medica; systematic study and practical verifications. Let us each carry a blank book always in our pocket, and spare a moment in the carriage, in the patient's house, in the office, between the acts at the theatre, or in the car, to jot down a verification and save it for the Society. Then we can every one of us bring in studies in materia medica; comparisons which arise when studying up a prescription. We shouldn't put all that work on our teachers. We can bring in studies which will be helpful in understanding, in remembering, in applying our remedies. We who were brought up in homœopathy, breathed it from our birth, cannot appreciate it; when we grow lazy or busy we are but too apt to allow the manufacturing druggist to do our prescribing for us. This is not a question of potency. We don't want the materia medica to drift into fights on high or low potencies, even if we mention the potency. It is a question of materia medica, pure and simple, in potency or no potency.

DR. SHELTON: I want to express my thanks to all the gentlemen who have spoken; but, gentlemen, that paper came from my heart, and I believe that if we do not inaugurate a speedy reform on this fundamental principle there will be no centennial of this Society; we may have a jubilee. We have no right to exist other than as a homœopathic society. Now, I am not standing for the homœopathic prerogative. I recognize that we are all physicians and that homœopathy comes second to the medical degree, but we are homœopathic physicians, because we know and believe it to be the best. If not, we are charlatans and recreant to a great and mighty trust! Dr. Hartman has brought something up to-day about the college. The college is not only one part of a medical education, but one part of a great

body politic. Those who try to teach must be backed up and their efforts must be supplemented by the preceptors. You get the student in the beginning, when he is in the class-book, formative stage, and he comes to us drifting oftentimes between a strict medical homœopathy and medical agnosticism. You preceptors are as much a part of the college as its dean, or its lowest tutor. I wish you would take this right down—when your student comes to us he must come to us with a purpose. You yourselves must come to us and follow these cases through our institution and your suggestions are most valuable ones. The closer the preceptor, the closer the college tie, the better for the interest of the school and everything concerned. There can be no rivalry. When our Admiral to whom the United States is going to do honor, was asked how he won the great fight in the Bay of Manila, in his modest way he replied, "That battle was won in the harbor of Hong Kong." And so it is the preliminary training of the student that makes the future man—not what he gets at the seat of action.

GORDON W. HOYT: I believe that we have all felt the force of Dr. Shelton's paper and discussion, and wish to announce that at the February meeting in Albany I shall endeavor to have an experience meeting in materia medica; I desire that every member of this Society shall hold himself in readiness to respond to any communication from the Chairman of this Bureau for a report or verification at that meeting.

VERBASCUM THAPSUS.

W. A. DEWEY, M. D.
ANN ARBOR, MICH.

Verbascum belongs to the scrophulariaceæ family or the scrofula curing order of plants. It has a thick stalk from eighteen inches to four feet high, with large, woolly, mucilaginous leaves, and with a long flower spike bearing plain, yellow, sessile flowers.

It is the common mullein and its name is derived from the Latin mollis, meaning soft. The name Verbascum is an altered form of the Latin barbascum, from barba, a beard, in allusion to the dense woolly hairs on both sides of the leaves. The name Thapsus is from its native place, the Island of Thapsus. There is a French word, molene, signifying "the scab" in cattle and the plant is famous for curing that disease in France. Other common names are cow's lungwort, Jupiter's staff, velvet dock, etc. The Greeks and Romans made lampwicks of its dried leaves and utilized its stalks, dipped in tallow, for funeral torches. It was also called "hag taper" because it was employed by witches in their incantations. It grows common everywhere in Europe and America.

Preparation.—Our homœopathic tincture is made from the fresh plant gathered in July as the plant comes into bloom. The method of Hahnemann is closely followed in the American Homœopathic Pharmacopœia, which should be followed closely in making the tincture since it was proved by him. Mullein oil is made by steeping the flowers in olive oil for twenty-one days, exposed to the sunlight.

Historical.—It has been used in medicine from ancient times. In Ireland it is still used in consumption; an infusion is given which palliates the cough, stays the expectoration and increases the weight. In Queen Elizabeth's time the leaves were carried about to prevent epilepsy, and distilled water of the flowers was said to be curative of gout. It undoubtedly possesses antiseptic and germicidal powers. Gerard says that figs wrapped in mullein leaves will not putrefy, and mullein oil has been found to be an admirable germicide. An infusion of the flowers was used by the Roman ladies to tinge their tresses a golden color, and a hair wash made from the mullein is highly valued in Germany even to this day. The dried leaves of mullein smoked in an ordinary tobacco pipe is a popular remedy for asthma and the hacking cough of consumptives in many parts of New England.

Mullein oil is a popular remedy in Germany for frost bites and piles and in this country it has of late been revived as a remedy instilled into the ear for deafness. Also it has been used in enuresis. Verbascum has no place in the United States Pharmacopœia. It was proved by Hahnemann and his disciples.

General Action.—The general action of verbascum, as obtained from the provings and subsequent clinical experience seems to be as follows:

1.—On the inferior maxillary branch of the fifth pair of cranial nerves.
2.—On the ear.
3.—On the respiratory tract.
4.—On the bladder.

Neuralgias.—The pathogenesis of verbascum abounds in neuralgic pains, for the most part referred to the parts supplied by the auriculo-temporal branch of the inferior maxillary nerve, namely the zygoma, the temporo-maxillary joint and the ear, particularly on the left side. It is therefore a useful remedy for neuralgia affecting these parts with coryza, lachrymation and a sensation, which is characteristic, as if the parts were crushed with tongs. Talking, sneezing and change of temperature greatly aggravate the pains. The pains seem to come in flashes and are excited by the least movement and by pressing the teeth together, showing the involvement of the inferior dental nerve. It occurs quite periodically, the same hour in the morning and afternoon of each day. Dr. Clotar Mueller cured a case of migraine with it on these symptoms and a drawing in the ear, and a sensation as if something had stopped the ear. The patient had suffered twenty years and Verbascum radically cured it.

Ear.—These neuralgic symptoms, rending otalgias with the sense of obstruction, especially indicate the remedy. Neuralgic earaches are

greatly benefited by its use. It has also deafness, and the use of mullein oil instilled into the ear has proved useful in a number of cases.

Respiratory.—The cough is of laryngeal and tracheal origin and it is especially marked by hoarseness; the voice is deep, harsh and hoarse, a "basso profundo"; it sounds like a trumpet. The cough is worse at night. It is a useful remedy in asthma and the chronic coughs of old people when there is much hoarseness.

Urinary.—There is a constant dribbling of urine—enuresis nocturna. Dr. Cushing claims that he does not know of a case where it failed to cure; he uses the 3x.

DISCUSSION.

J. T. O'CONNOR: I would like to correct what I think is an error in the paper in regard to the method of production of mullein oil. Mullein oil—as I remember Dr. Cushing's letter about it, and that letter was repeated some years later—is made by putting the crushed stalk and leaves into a large bottle without olive oil, letting it hang up in the sun, when there is distilled an oily liquid. I do not think that there would come out anything from the leaves and stalks steeped in olive oil. The oil is an entirely different preparation from the tincture of verbascum thapsus and from the tincture are made our potencies. I must confess that the range of action of that drug is better known to me since I read this paper than before, for I remember reading in very black type in Lilienthal's "Therapeutics" that it is the remedy where the neuralgia has that peculiar sense of crushing as with tongs, and that is all that I knew of it. I have prescribed it in one or two bad cases of neuralgia and I don't think I got any result. Possibly I waited until I got a case in which that special symptom was present and possibly it was a case otherwise not fitted for the drug. I did not know it had been used to any extent in our school outside of that line. I had forgotten Dr. Cushing's statement that he used it for enuresis nocturna; that is a valuable point. In regard to asthma, as the paper spoke of getting relief from paroxysms of asthma by smoking it in a pipe, I used to have asthma and if it is like stramonium, I would rather have the asthma, for stramonium smoke is so hot; but in speaking of smoking, incidentally I will give a little bit of experience. Asthma is a horrible disease to suffer from; anything that will give relief will be welcomed. I remember a Dr. Bridges who was at one time assistant to Dr. A. R. Thomas, of Philadelphia. I was suffering a great deal then, in fact it was from the effect of homœopathic remedies on me in curing my asthma that I became a homœopath. Dr. Bridges told me to get a pipe and half fill it with tobacco, and to get some white arsenic—the real stuff—and to add as much of it as would lie on the point of a pen-knife blade—about a quarter of a grain—then fill up with tobacco and light. When the fire got down to the arsenic of course the garlic smell was quite apparent. Many a time—perhaps twenty or thirty times—I have gotten great relief inside of fifteen minutes from that. But as I grew older

and began to study medicine, I thought it was rather dangerous, so did not try it very often. Another thing in regard to asthma is the peculiarity that a drug at one time will give great relief and at other times will be useless. There is J. Whitcomb's asthma remedy which once relieved me inside of fifteen minutes and I thought I had a sure cure for asthma. The next time I had an attack of asthma I took that remedy and it made me worse. Those are important points. There are others in regard to neuralgia. The doctor sets it down with several symptoms, not only that peculiar crushing pain, but the presence of coryza, I think, and that is a point to bear in mind.

PRESIDENT SHELDON: For over a year and a half I suffered with constant tinnitus in my right ear, with slight deafness; the noise was like the singing of insects. Not only had I prescribed to the best of my ability but three specialists treated me without any very great benefit. I dropped two or three drops into my ear every other night for a few weeks then at intervals for four or five months, and now the annoying noise has ceased. I have prescribed diluted mullein oil internally for enuresis nocturna, with great relief.

L. A. MARTIN: There seems to be a diversity of opinion as to the preparation of this oil. It was my impression that the oil was distilled by the rays of the sun on the mullein flower (and not the plant or leaf). The flowers and buds are put into glass and exposed to the rays of the sun to from three to six weeks, and the distillation produced the oil.

W. L. HARTMAN: I interested myself in the subsequent preparation of this and I asked a proprietor how to prepare it. His partner made a business of gathering the flower and that was every year; his partner goes down into the Eastern States and gathers quantities of it every year, and that is the way he told me it was prepared; the flowers were put in a bottle and allowed to distill; he informed me there was no oil about it at all.

GORDON W. HOYT: I wish to state a little experience that I had with verbascum with a cough in a child. The irritation seemed to be in the throat with this symptom; if the child would draw in a long breath it would prevent the paroxysm. Verbascum[3], I think about four or five doses, cured the cough.

APPENDIX.

Necrologist's Report.....W. S. GARNSEY.
Obituaries of—
WILLIAM S. TALCOTT, by W. I. Pierce.
SUE A. WHITE.
THEODORE C. WHITE.
Biographical Sketch of President SHELDON.
Constitution and By-Laws.
Standing Resolutions.
Honorary Members.
Chronological Table of Officers.
Delinquent ex-Members.
Roll of Members.
Openings for Practice.
State Directory.

Necrologist's Report.

WILLIAM S. TALCOTT, M. D.

BY WILLARD IDE PIERCE, M. D.

Dr. William S. Talcott, of 223 West 135th St., New York City, died very suddenly on July 15, 1898, in his 60th year. For a number of years he had not been in robust health, but other than having asthmatic attacks had not been confined to his house. On the day of his death he had been to the New York Homœopathic Medical College Dispensary to look after his clinic and was taken sick with what he considered one of his asthmatic attacks on his way home and died half an hour after reaching home. He was a graduate of the New York Homœopathic Medical College and Hospital of the class 1870 and while his health would never permit his taking any very active part in the meetings and doings of his professional associates, he had their universal respect and was known as a very conscientious physician and careful prescriber.

SUE A. WHITE, M. D.

Dr. Sue A. White died at her home on Clinton Place in Utica, March 20, 1899, from pneumonia and Bright's disease, after an illness of about two weeks.

She was a daughter of Hon. Nicholas A. White, owner of White's pottery and at one time a member of the State Legislature. She was born in Utica, March 25, 1845, and received her early education in the Utica schools. After graduating from the Free Academy she took up the profession of teaching and taught successfully for several years in the old Whitesboro street school. She subsequently decided to study medicine and entered the medical department of Boston University, from which she graduated in 1873. After a post-graduate course in the New York Post-Graduate Medical College and Hospital she began the practice of her profession in Chicago. After several years of successful practice she returned to Utica in 1882 and has practiced there ever since.

Dr. White enjoyed a very large practice and being of strong constitution she never seemed to tire of the arduous duties of her profession. She was always ready to respond to the call of those who were suffering, and she accomplished an enormous amount of work with apparently little effort. She made a specialty of the diseases of women and children and was often called in consultation by other physicians throughout the country. She considered her patients first and her devotion to their suffering was largely the cause of her illness. Her clientage was very large and it extended through Central New York.

Dr. White was one of the founders of the Utica Homœopathic Hospital and was for years on its medical staff. Since it has occupied a building of its own she has been on the staff of the Home for Aged Men and Couples. She was a member of the Oneida County Medical Society and served as its president for some years. She was also a member of the State Homœopathic Society. She was one of the charter members of the new Century Club, and was one of its most ardent supporters, often giving lectures pertaining to health before the club. She was compelled to retire, however, owing to her numerous professional duties. She was also one of the founders of the Working Woman's League and reading room and did much to promote its welfare. She was a member of the Daughters of the American Revolution, and of the First Presbyterian Church. For some time she gave lectures every fortnight at Folt's Institute in Herkimer. She was a pleasing and interesting speaker and made an enviable reputation as a speaker and writer on health subjects.

THEODORE C. WHITE, M. D.

Dr. Theodore C. White, of Rochester, died November 18, 1898, at the residence of his nephew, Dr. Charles R. Sumner. He had been sick nearly a year. He was born in Stamford, Conn., in 1834. He studied medicine with Dr. Cox in Albany, and later in the Albany

Medical College, from which he graduated in 1859. His entire public life was spent in Rochester. He married in 1890, but left no children.

He was a member of the Monroe County Society; the Western New York, and the New York State Homœopathic societies, in all of which he had held offices. He was very active on the medical board of the Rochester Homœopathic Hospital, and was president of its medical and surgical staff at the time of his death. He had a large and lucrative practice, and was dearly beloved by very many.

BIOGRAPHICAL SKETCH OF PRESIDENT JAY WINFIELD SHELDON, M. D.

By J. Willis Candee, M. D.

Dr. Jay Winfield Sheldon was born in Otego, Otsego County, February 12, 1837. His father, Henry Sheldon, of English descent, was an architect and builder of note in that region. The subject of this sketch received his education in the schools of his native town. At the age of 21 he began the study of medicine in the office of an old school physician; later he became a convert to homœopathy, was a student in the office of Dr. S. C. Warren, of Otego, for a period of two years, and in 1864 was graduated from the then Cleveland (Ohio) Homœopathic Hospital College. After a short but active experience in country practice, he located in Syracuse, January 1, 1865, entering into partnership with the late Dr. Lyman Clary, who was one of the pioneers of homœopathy in Central New York. In 1879 he formed a co-partnership in practice with Dr. J. W. Candee, which still continues.

Through love of his professional work, coupled with determination to succeed, Dr. Sheldon soon acquired and has maintained a large and lucrative practice. He is the dean and the most striking representative of the homœopathic practitioners of Onondaga County. His unfaltering loyalty to homœopathy and tireless efforts in its behalf have commanded admiring recognition throughout the profession. Dr. Sheldon is known in the community where he has so long resided as possessing keen perception, well-balanced judgment and rare executive ability, and is considered a wise and progressive leader.

He has been frequently selected to fill honorable and responsible positions. He was appointed on August 13, 1864, assistant surgeon of the Seventy-fifth Regiment, National Guard, State of New York, and served until the regiment was disbanded. He has since 1864 been a prominent member of the Onondaga County Homœopathic Medical Society, and is an ex-president of that body. In 1870 he became a member of the American Institute of Homœopathy and, since 1895, a Senior.

In 1885 he was elected to membership in this Society, and was made a vice-president in 1891. For many years Dr. Sheldon served as a

member of the committee on medical legislation, in which capacity he has been able to render invaluable service to the Society and to the cause of homœopathy. During the seven years' struggle which culminated in the enaction of the present medical examining and licensing laws, he was a potential force of recognized power on the side of justice to homœopathists, and his aid was never sought in vain. At the annual meeting of the Society in 1899 he was unanimously elected its president.

He was one of the original members, and for several years president of the Syracuse Homœopathic Medical Association and was also a charter member and an officer of the Syracuse Homœopathic Free Dispensary. In 1890 he was made an honorary member of the Albany County Homœopathic Medical Society. Receiving appointment as a State Homœopathic Medical Examiner, he served on the Examining Board two years, from September 1, 1891, acting as the first incumbent in the department of materia medica, therapeutics and practice. Upon the organization of the Syracuse Homœopathic Hospital, he was appointed a consulting physician and was elected president of the staff, and continues to serve in each capacity.

During hours of leisure Dr. Sheldon has identified himself with various forms of benevolent and charitable work. One of these, in which he has taken deep interest, is the Young Men's Christian Association; with this organization he has been actively identified for many years, having served as its vice-president and for a long time as chairman of the finance committee. He attends the First Presbyterian Church. He is a member of the Citizens' Club, the Chamber of Commerce and the Lakeside Yacht Club, also of Central City Lodge No. 305, F. & A. M. and of the Central New York Masonic Veterans' Association.

In politics he is an ardent Republican, having been an active member of that party since its organization. He was for several years president of the Onondaga County Republican League.

By means of untiring energy, unusual sagacity and enthusiastic devotion to the practice of his profession, Dr. Sheldon has for more than thirty years been recognized, both in Syracuse and without, as one of the most popular, influential and reliable of its physicians. He is, in the best sense, a self-made man. In the community where he resides he is held in high esteem as an honorable and upright man and is recognized as one of its distinguished citizens.

Dr. Sheldon was married September 12, 1860, to Emily J. Betts, of Memphis, Onondaga County. They have one daughter, Mrs. A. H. Gleason, of New York City.

CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—NAME.

§ 1. In pursuance of Chap. 268, Laws of 1862, by which it was incorporated, this association shall be known as the Homœopathic Medical Society of the State of New York.

§ 2. Its objects shall be the advancement of homœopathic therapeutics and of all other departments of medicine and surgery.

ARTICLE II.—MEMBERS.*

The Society shall be composed of permanent members, of delegates from homœopathic county societies and corporate institutions or associations of this State, and of such other members as may be chosen in conformity with the By-Laws.

ARTICLE III.—OFFICERS.

§ 1. The officers of this Society shall be a president, three vice-presidents, a secretary, treasurer, necrologist and twelve censors (three of whom shall be selected from each of the four Censorial Districts of the State), who shall be elected by ballot by a majority of the active members present at each annual meeting.

§ 2. Their term of office shall commence at the close of the meeting at which they are elected, and shall continue for one year, until the adjournment of the next annual meeting, and until their successors are elected.

ARTICLE IV.—SEAL.

The subjoined, either printed or embossed, shall be the official seal of the Society.

*This Society "may elect such a number of permanent, delegate or other members as may be provided for by the constitution and by-laws," and is "empowered to regulate and control its own membership." Laws of 1882, Chap. 209.

ARTICLE V.—MEETINGS.*

§ 1. The annual meeting shall be held each year at Albany, commencing on the second Tuesday in February.

§ 2. A semi-annual meeting may be held at such time and place as the Society shall determine.

§ 3. Special meetings may be called by the Executive Board, or by the President upon the call of ten active members.

ARTICLE VI.—QUORUM.

Ten active members shall constitute a quorum.

ARTICLE VII.—AMENDMENTS.

Any article of this constitution may be amended at an annual meeting by a two-thirds vote of the active members present, provided that a written notice shall have been given at the preceding annual meeting.

*This Society may select the time and place for holding its annual and other meetings. Laws of 1875, chap. 449.

BY-LAWS.

ARTICLE I.—DUTIES AND ELECTION OF OFFICERS.

§ 1. The duties and responsibilities of the president, vice-presidents, secretary, treasurer and necrologist shall be such as are usually incident to these offices.

§ 2. The President shall deliver an address at the annual or semi-annual meeting, appoint standing committees, bureaus and delegates, make appointments to fill vacancies and be ex-officio member of all committees.

§ 3. The Secretary, in addition to his other duties, shall annually edit the Transactions of the Society and the State Directory of Homœopathic Physicians, consulting with the Executive Board when he or they deem it necessary. He shall divide the delegate members into four classes as nearly equal as possible, one of which classes shall go out of office each year.

He shall be paid a salary of two hundred and fifty dollars per annum.

§ 4. The Treasurer shall keep the funds of the Society in a bank or trust company approved by the Executive Board, and the account shall stand in the name of the Society.

Each year he shall furnish a copy of the current issue of the Transactions to each permanent and senior member in good standing, and shall send to each county society not in arrears as many copies as it is entitled to delegates.

At each regular meeting he shall announce the names of such applicants as shall have failed to qualify for membership.

At each annual meeting he shall report the names of such members, institutions and county societies as are dropped for non-payment of dues, and shall furnish the tellers with a list of the active members entitled to vote.

He shall turn over to his successor all property of the Society in his charge.

In lieu of salary he shall be reimbursed for his traveling expenses incurred in attending the meetings of the Society.

§ 5. It shall be the duty of the Censors to consider all applications for permanent membership, reporting to the Society at the same or next meeting such as they judge to be properly qualified for election.

Three shall constitute a quorum.

§ 6. Officers shall be voted for together on a ballot to be deposited, by each active member voting, between the hours of twelve and twelve-thirty p. m. on the second day of the annual meeting.

Within one hour after the closing of the poll the tellers shall make report.

In case of failure to elect, another ballot for the office or offices to be filled shall be ordered held at once or at a subsequent session.

The tellers shall receive no ballot unless notified by the Treasurer that the member wishing to vote has paid his or her dues, in evidence of which shall be the list furnished the tellers by the Treasurer or his receipt for the dues in question.

ARTICLE II.—MEMBERSHIP.

§ 1. By the term "active members" is meant such permanent, delegate and senior members as are in good standing.

§ 2. Any physician desiring Permanent Membership must be of good moral and professional standing, and legally licensed to practice medicine under the laws of this State.

The candidate must sign the following form, properly filled out and indorsed: "I request membership in the Homœopathic Medical Society of the State of New York, and agree, if elected, to pay my dues promptly and regularly to the Society. I hereby acknowledge that I believe Similia Similibus Curantur. I reside at No..... in.....county of.....and am a graduate of.....in the year.....(signed) (date). The undersigned permanent members indorse the above applicant as worthy of permanent membership in this Society. (Signed).....and.....

After having been favorably reported on by the Censors and accepted by a majority vote of the active members present at a regular meeting, the candidate, upon the payment of five dollars, shall become a permanent member entitled to the rights and privileges of membership, including a certificate of membership.

If the first year's dues be not paid before the regular meeting next succeeding his or her election, such election shall be void and his or her name shall be published each year in a special list in the back of the Transactions.

The first, second, third and fourth paragraphs of this section shall be printed upon the application blanks.

§ 3. Each homœopathic county society in this State is entitled to elect, for a term of four years, as many Delegate Members of this Society as there are assembly districts in that county.

Permanent members shall not be eligible, and every delegate becoming a permanent member shall thereby cease to be a delegate member.

Each incorporated homœopathic institution or association in this State shall be entitled, upon payment of the annual dues, to single delegate representation in this Society, the term of the delegate to be four years.

Delegate members in good standing have all the rights and privileges of permanent membership except the certificate, eligibility to senior membership and election to the presidency.

§ 4. Any permanent member may be elected a Senior Member at an annual meeting, provided that at the time of such election he or she is in good standing and shall have paid dues for twenty years.

Senior members shall be exempt from dues and assessments, and shall be entitled to all rights and privileges of membership.

§ 5. Any physician or surgeon not a resident of this State, who has manifested superior attainments in medicine or one of its collateral sciences, may be elected an Honorary Member at an annual meeting, provided that the nomination, accompanied by reasons for conferring the honor, shall have been made at a previous regular meeting. Not more than three honorary members shall be elected in any one year.

Honorary members may participate in the proceedings of this Society (except that they shall not vote nor be eligible to office) and are requested to contribute papers. They shall be entitled to receive the volumes of Transactions to which they contribute papers.

ARTICLE III.—DUES.

§ 1. The annual dues shall be three dollars from each permanent member and from each institution or association which appoints a delegate; from each county society there shall be due three dollars per annum for each delegate to which that society is entitled.

§ 2. Each permanent member shall pay a membership fee of five dollars, which shall include the dues for the current year, at the time of his or her election.

§ 3. No member in arrears shall be entitled to the privileges of membership.

Members three years in arrears shall be dropped from the roll, and their names published each year in a special list as having been dropped for non-payment of dues.

ARTICLE IV.—COMMITTEES AND BUREAUS.

§ 1. The Executive Board, consisting of the president, vice-presidents, secretary, and treasurer, shall act as the executive committee of the Society, attending to matters not otherwise provided for, or that may be referred to it.

When necessary it may call a special meeting of the Society, specifying time, place and object.

It shall serve as an advisory committee of publication with discretionary power as to the appearance in the Transactions of any given report or paper.

§ 2. The President-elect shall annually appoint the chairman of the Committee on State Medical Examiners and a chairman, with at least two members, of the Committee on Legislation and of each of the following bureaus: Materia Medica, Clinical Medicine and Pathology, Surgery, Obstetrics, Gynæcology, Pædiatrics, Neurology, Ophthalmology and Otology, Laryngology and Rhinology, and Public Health.

ARTICE V.—PAPERS.

§ 1. All papers, communications and reports read before or presented to this Society become thereby its property, and must be at once deposited with the Secretary. They may afterward, by means of copies, be published in medical journals if due credit be given to this Society.

§ 2. No paper nor report shall be received for publication in an unfinished condition.

§ 3. Only fifteen minutes shall be allowed for the reading of a paper, ten minutes each for its opening and closing discussion, and five minutes each for other remarks discussing it. This rule may be suspended only by the unanimous consent of those present.

ARTICLE VI.—STATE MEDICAL EXAMINERS.*

§ 1. This Society shall at each annual meeting, by a majority vote, nominate to the Regents of the University for appointment as State Medical Examiners at least twice as many persons as there are appointments to be made.

§ 2. Each nominee must be a member of this Society in good standing, must have been graduated in course from a reputable medical college, and must have been practicing medicine or surgery under the laws of this State for at least five years immediately prior to the first of July following said nomination.

§ 3. The Secretary shall send to each permanent and delegate member of this Society, a week before the annual meeting, the nominations by the Committee on State Medical Examiners of at least three times as many nominees as there are appointments to be made.

Each active member present may, between twelve and twelve-thirty p. m. of the second day of the annual meeting, deposit with two special tellers appointed by the president, a ballot for at least twice as many nominees as there are appointments to be made. Such names as receive a majority of the votes cast shall be presented to the Regents.

In case a sufficient number of names (twice the number of appointments to be made) do not receive a majority vote, the quota shall be filled by a ballot upon names submitted in open nomination.

§ 4. If charges of unprofessional or dishonorable conduct or continued neglect of duty are made against any State Medical Examiner representing this Society, the Society, after considering the matter in Committee of the Whole, may by a majority vote at any regular or special meeting submit the evidence in the case to the Regents and may request the removal of said Examiner.

§ 5. The Committee on State Medical Examiners shall consist of five members, to be elected by ballot at the annual meeting. The chair-

*Laws of New York, 1890, Chap. 507.

man shall be appointed from among their number by the president-elect within three weeks. Their term of office shall commence at the close of the meeting at which they are elected and shall continue one year, to the close of the next annual meeting, and until their successors are elected.

ARTICLE VII.—ORDER OF BUSINESS.

At the meetings of this Society the following shall be the Order of Business, unless otherwise prescribed by the Executive Board or changed by the Society.

Prayer.
Communication from the President.
Appointments:
- Committee on Attendance;
- Committee on President's Address;
- Auditing Committee;
- Tellers.

Minutes of the last meeting.
Report of the Board of Censors.
Elections:
- of Members—Permanent, Senior, Honorary;
- of Officers (at time specified);
- of Nominees as State Medical Examiners (at time specified);
- of Committee on State Medical Examiners.

Reports:
- of Officers;
- of Committees;
- of Bureaus.

Miscellaneous business.

ARTICLE VIII.—GOVERNMENT.

This Society shall be governed by the Code of Ethics adopted by the American Institute of Homœopathy, and by parliamentary usage as set forth in Roberts' Rules of Order for Deliberative Assemblies.

ARTICLE IX.—AMENDMENT.

These By-Laws may be amended by a two-thirds vote of the active members present at an annual meeting, provided that written notice shall have been given at a previous regular meeting.

STANDING RESOLUTIONS.

DELINQUENT MEMBERS.

Whereas, It has been proposed that members dropped for non-payment of dues, asking to be reinstated should have their back dues remitted, and

Whereas, It would seem that such action would be prejudicial to the best interests of the Society by encouraging delinquency; therefore

Resolved, That the power of re-instatement in such cases be vested in the Executive Board, with the understanding that such leniency shall be exercised only in exceptional cases where unfortunate circumstances seem to render it necessary.

Adopted, Feb. 9, 1892.

ANNUAL REPORT OF STATE MEDICAL EXAMINERS.

At each annual meeting the chairman of our Board of State Medical Examiners shall make a report to us of the work done by the Board during the year.

Adopted, Feb. 14, 1893.

PAPERS BY TITLE.

Resolved, That when the writer of a paper is not in attendance upon the meeting at which it is presented, the said paper shall be read by title. The only exception to be made to this rule shall be when the work of the Society is ahead of the schedule in point of time.

Adopted, Feb. 12, 1895.

POSTAL NOTICE.

Not more than three nor less than two weeks previous to every regular meeting the Secretary shall send to each member a (postal card) notice of its date and place.

Adopted, Feb. 8, 1898.

HONORARY MEMBERS.

		Elected.
Allen, Henry C.....	5142 Washington Ave., Chicago, Ill.,	1886
Bartlett, Clarence.....	1402 Spruce St., Philadelphia, Pa.,	1890
Biggar, Hamilton F....	Cleveland, O.,	1887
Blake, J. Gibbs.....	England,	1882
Breyfogle, W. L.....	New Albany, Ind.,	1881
Budlong, John C.....	Providence, R. I.,	1881
Clifton, Arthur C.....	9 Park Parade, Northampton, Eng.,	1888
Corbin, John L.....	245 Main St., Athens, Pa.,	1883
De Derkey, F. F.....	311 W. 3d St., Los Angeles, Cal.,	1881
Drummond, John.....	Manchester, Eng.,	1870
Dudgeon, R. E.....	53 Montague Sq., London, W., Eng.,	1867
Duncan, T. C.....	100 State St., Chicago, Ill.,	1869
Edie, John L.....	Leavenworth, Kan.,	1870
Gallinger, J. H.....	Concord, N. H.,	1881
Gilchrist, James G.....	215 College St., Iowa City, Ia.,	1888
Hale, Edwin M.....	65 Twenty-second St., Chicago, Ill.,	1865
Hayward, John W.....	61 Shrewsbury Road, Birkenhead, Cheshire, Eng.,	1882
Heath, Edwin R.....	Kansas City, Kan.,	1868
Henderson, William.....	Edinburgh, Scotland,	1869
Hirschel, B.....	Dresden, Saxony, Germany,	1871
James, Bushrod W.....	Green and 18th Sts., Philadelphia, Pa.,	1868
Jones, Samuel A.....	Ann Arbor, Mich.,	1882
Kinne, Theodore Y.....	Paterson, N. J.,	1893
Linnell, E. H.....	61 Broadway, Norwich, Conn.,	1891
Madden, H. R.....	London, Eng.,	1870
Mandeville, F. B.....	Newark, N. J.,	1873
McGeorge, Wallace.....	521 Broadway, Camden, N. J.,	1884
Morgan, John C.....	Millville, N. J.,	1869
Peck, George B.....	865 N. Main St., Providence, R. I.,	1882
Pope, Alfred C.....	Grantham, Eng.,	1871
Potter, Samuel.....	San Francisco, Cal.,	1881
Roth, Mathias.....	London, Eng.,	1871
Runnels, O. S.....	203 N. Meridian St., Indianapolis, Ind.,	1882
Sanders, John C.....	608 Prospect St., Cleveland, O.,	1865
Skinner, Thomas.....	6 York Pl., London, W., Eng.,	1878
Sparhawk, George E. E..	Burlington, Vt.,	1875
Wesselhoeft, Conrad....	291 Boylston St., Boston, Mass.,	1888
Wilson, David.....	London, Eng.,	1865
Wood, James C.....	122 Euclid Ave., Cleveland, O.,	1891
Worcester, Samuel.....	31 Winter St., Portland, Me.,	1873

OFFICERS, 1850—1899.

Year.	Presidents.	1st Vice-President.	2nd Vice-President.	3rd Vice-President.	Secretary.	Treasurer.	Cor. Secretary.
1850.	*Isaac M. Ward, Albany.	*D. Chase.	*R. S. Bryan.	*A. S. Ball.	*Henry D. Paine.		
1851.	*F. Vanderbergh, New York.	*L. Clary.	*F. Humphreys.	*Geo. W. Lewis.	"		
1852.	*Lyman Clary, Syracuse.	*Alonzo S. Ball.	*E. L. Coburn.	*D. Chase.	"		
1853.	*Alonzo S. Ball, New York.	*N. H. Warner.	S. S. Guy.	*L. B. Wells.	"		
1854.	*Amherst Childs, Waterloo.	*Henry Adams	*Josiah Bowers.	*E. T. Richardson.	"		
1855.	Samuel S. Guy, Brooklyn.	*M. M. Matthews.	*R. S. Bryan.	*David Springsteed.	"		
1856.	*M. M. Matthews, Rochester.	*J. M. Quinn.	*Henry Adams.	*L. B. Wells.	"		
1857.	*R. S. Bryan, Troy.	*A. P. Cook.	*L. B. Wells.	*J. C. Peters.	"	*J. W. Cox.	
1861.	*Ethan A. Potter, Oswego.	*Simeon A. Cook.	A. R. Wright.	*Cornelius Ormes.	Horace M. Paine.	*J. W. Cox.	
1862.	*Jacob Beakley, New York.	A. R. Wright.	*E. A. Munger.	W. S. Searle.	"	*L. B. Wells.	
1863.	*Henry D. Paine, New York.	*William Wright.	C. W. Boyce.	Asa S. Couch.	"	"	
1864.	*Erastus A. Munger, Waterville.	S. S. Guy.	A. R. Morgan.	"	"	"	
1865.	*Abijah P. Cook, Hudson.	*Benj. F. Cornell.	*Benj. F. Bowers.	*L. M. Kenyon.	"	"	H. B. Fellows.
1866.	*Horatio Robinson, Auburn.	*Lucien B. Wells.	*Wm. B. Stebbins.	*Edgar B. Cole.	"	*J. S. Delavan.	"
1867.	*B. F. Cornell, Moreau Station.	*S. B. Barlow.	William H. Watson.	L. M. Pratt.	H. B. Fellows.	*J. W. Cox.	*E. D. Jones.
1868.	William H. Watson, Utica.	T. F. Allen.	*T. L. Brown.	*D. F. Bishop.	H. M. Paine.	W. S. Searle.	"
1869.	*William Wright, Brooklyn.	E. B. Holmes.	*Henry Minton.	*E. P. K. Smith.	"	"	"
1870.	*Lucien B. Wells, Utica.	*Edwin H. Hurd.	*Ezra P. K. Smith.	T. Franklin Smith.	"	"	"
1871.	*John F. Gray, New York.	T. Franklin Smith.	J. C. Raymond.	*A. W. Holden.	"	*J. F. McKown.	"
1872.	*H. A. Houghton, Keeseville.	*Charles Sumner.	H. S. Hutchinson.	G. L. Gifford.	"	Nelson Hunting.	L. M. Pratt
1873.	*E. Darwin Jones, Albany.	*D. F. Bishop.	*J. Ralsey White.	R. E. Miller.	*Frank L. Vincent.	Nelson Hunting.	L. M. Pratt.

*Deceased.

1874.	*L. M. Kenyon, Buffalo.	*A. E. Sumner.	*S.C.Knickerbocker.	*Henry Sales.	*F. L. Vincent.	*F. L. Vincent.	L. M. Pratt.
1875.	*A. W. Holden, Glens Falls.	E. M. Kellogg.	*H. V. Miller.	R. S. Bishop.	"	*E. D. Jones.	"
1876.	T. F. Allen, New York.	A. R. Wright.	William Gulick.	Henry R. Stiles.	Alfred K. Hills.	*F. L. Vincent.	"
1877.	Egbert Guernsey, New York.	William Gulick.	Henry R. Stiles.	H. D. Brown.	"	E. S. Coburn.	H. L. Waldo.
1878.	William Gulick, Watkins.	A. R. Wright.	W. M. L. Fiske.	A. P. Throop.	"	"	"
1879.	Asa S. Couch, Fredonia.	Alfred K. Hills.	E. Hasbrouck.	J. J. Mitchell.	H. L. Waldo.	"	*A. P. Hollett.
1880.	A. R. Wright, Buffalo.	E. Hasbrouck.	*N. Osborne.	R. A. Adams.	"	"	"
1881.	Selden H. Talcott, Middletown.	J. J. Mitchell.	A. J. Frantz.	*G. W. Peer.	*A. P. Hollett.	"	*C. E. Jones.
1882.	J. J. Mitchell, Newburgh.	E. Hasbrouck.	W. B. Kenyon.	W. M. Butler.	"	"	NECROLOGIST
1883.	Everitt Hasbrouck, Brooklyn.	W. B. Kenyon.	A. P. Williamson.	L. A. Clark.	"	"	*A. W. Holden.
1884.	Edward S. Coburn, Troy.	Henry C. Houghton.	*H. M. Dayfoot.	*A. P. Hollett.	John L. Moffat.	H. L. Waldo.	"
1885.	Marshall O. Terry, Utica.	*A. P. Hollett.	N. B. Covert.	George M. Dillow.	"	E. S. Coburn.	"
1886.	Henry C. Houghton, New York.	F. Park Lewis.	*T. L. Brown.	E. W. Bryan.	*H. M. Dayfoot. "	"	"
1887.	Horace M. Paine, Albany.	Wm. Tod Helmuth.	J. M. Lee.	Geo. E. Gorham.	"	"	"
1888.	Wm. Tod Helmuth, New York.	Thos. D.Spencer.	*L. A. Bull.	John L. Moffat.	"	Arthur B. Norton.	"
1889.	*Herbert M. Dayfoot, Rochester.	F. F. Laird.	J. T. Greenleaf.	Sidney F. Wilcox.	John L. Moffat.	"	H. L. Waldo.
1890.	George M. Dillow, New York.	N. B. Covert.	J. M. Lee.	W. B. Gifford.	"	"	"
1891.	F. Park Lewis, Buffalo.	A. B. Norton.	L. L. Brainard.	J. W. Sheldon.	"	Charles Deady.	H. D. Schenck.
1892.	Wm. M. L. Fiske, Brooklyn.	*L. A. Bull.	E. J. Bissell.	J. W. Candee.	"	"	"
1893.	J. M. Lee, Rochester.	J. W. Candee.	W. J. Garnsey.	Mary A. Brinkman.	"	"	E. Hasbrouck.
1894.	Jas. Montfort Schley, New York.	E. J. Bissell.	W. B. Gifford.	W. B. Winchell.	"	"	"
1895.	*Charles E. Jones, Albany.	W. B. Gifford.	D. J. Roberts.	W. L. Hartman.	"	"	"
1896.	Edwin H. Wolcott, Rochester.	G. G. Shelton.	I. Townsend.	A. R. Wright.	"	"	W. S. Garnsey.
1897.	Eugene H. Porter, New York.	John W. Le Seur.	J. W. Dowling.	E. G. Cox.	"	"	"
1898.	A. B. Norton, New York.	D. G. Wilcox.	F. W. Adriance.	H. D. Schenck.	"	"	"
1899.	J. W. Sheldon, Syracuse.	F. W. Adriance.	G. E. Gorham.	N. M. Collins.	"	"	"

MEMBERS DROPPED FOR NON-PAYMENT OF DUES.

(*By-Law III, §3. ¶2.*)

Albertson, C. S.....1895
Anderson, H. A.....1898
Banker, P. A.....1898
Bass, E. C.....1884
Beach, G. H.....1884
Bigelow, J. G.....1884
Blighton, W. V-R.....1898
Blodgett, T. L.....1884
Bloss, R. D.....1884
Boyce, C. W.....1885
Bradner, Ira S.....1889
Brown, H. D.....1884
Bull, A. T.....1884
Campbell, C. E.....1891
Campbell, M. W.....1884
Carpenter, L. W.....1898
Carr, A. B.....1892
Chamberlain, J. H.....1894
Chase, C. E.....1898
Clark, A. J.....1889
Coffin, W. H.....1888
Cowl, W. Y.....1894
Curtiss, A. M.....1895
Dake, Addie B.....1894
Dewey, W. A.....1898
Diehl, W.....1898
Dods, A. Wilson.....1888
Doolittle, J. F.....1889
Finch, Joseph.....1887
Fisher, E. A.....1895
Fiske, Katrina C.....1898
Flint, E. H.....1895
Fulford, G. H.....1888
Fuller, H. E.....1890
Gallup, M. W.....1889
Gamman, A. M.....1893
Gifford, B. R.....1890
Gifford, G. A.....1884
Grant, B. F.....1888
Greeley, G. H.....1884
Groves, C. A.....1893
Gwynn, W. M.....1884
Hadley, W. A. M.....1898
Halbert, John S.....1896
Hale, C. D.....1888
Hand, George F.....1895
Hanford, Harold W.....1896
Hanford, S. C.....1884
Hanford, W. H.....1884
Hanor, Azro Chase.....1896
Hathaway, W. E.....1893
Hawley, W. A.....1884
Hibbard, G. C.....1884
Houghton, B. L.....1893
King, G. H.....1888
Lewis, G. W., Jr.....1892
Linendall, R. A.....1889
Lindsey, J. S.....1887
Long, William E.....1892
Loomis, E.....1883
Lowery, C.....1884
MacIvor, Abbie H.....1898
Marsh, James M.....1896
McKenzie, J. E.....1898
McKinney, Susan S.....1898
McPherson, J. C.....1892
Miller, Isaac.....1886
Millspaugh, C. F.....1890
Moore, J. de V.....1892
Morgan, E. J., Jr.....1887
Mosher, Charles M.....1892
Nash, E. B.....1890
Otis, Clark.....1892
Palmer, G. B.....1890
Pearsall, S. J.....1898
Peckham, J. J.....1888
Peterson, O. W.....1889
Pritchard, G. C.....1898
Proctor, J. C.....1893
Raymond, J. C.....1883
Reynolds, P. L. F.....1884
Rice, A. B.....1886
Robinson, E. H.....1898
Robinson, R. W.....1895
Rodenberger, E. M.....1898
Seegar, F.....1893
Seeley, W. W.....1893
Smith, Sidney E.....1898
Stebbins, J. H.....1893
Stobbs, A. V.....1888
Sweeting, M. F.....1884
Sweeting, S. C.....1898
Swift, Charles L.....1884
Thorn, Sarah E.....1892

Tracy, G. A.....1888
True, R. S.....1892
Truman, I. P.....1889
Voak, J. B.....1891
Wallace, A. E.....1884
Walters, C. A.....1898
Ward, H. J.....1884
Warren, S. C.....1884
Weed, Robert M.....1891
Welch, C. D.....1891
Wellman, W. I.....1888
West, James A.....1892
White, J. N.....1884
White, W. Hanford.....1888
Whiton, Alpha M.....1895
Winterburn, G. W.....1898
Woodbury, W. L.....1886
Wright, F. M.....1890
Young, C. H.....1898
Zoller, W.....1888

MEMBERS-ELECT WHO FAILED TO QUALIFY.

Archer, D. E.....1894
Ayres, E. F. M.....1899
Barnum, F. L.....1894
Bennett, D. G.....1894
Campbell, E. E.....1893
Chaplain, F. T.....1881
Conklin, Fannie Donovan...1899
Dyer, Charles L.....1895
Evans, C. V. S.....1894
Fairbank, Stuart J.....1899
Gifford, Alden.....1892
Hodge, John W.....1899
Kaiser, R. C.....1894
Knight, S. H.....1893
McKenzie, J. A.....1895
Read, J. S.....1891
Reed, J. A.....1894
Wilcox, F. P.....1893
Zimmermann, Charles.....1892

PERMANENT MEMBERS.

(*Senior Members in Small Capitals.*)

Adams, George F.....Collins State Hospital, Gowanda, 1898
Adams, Myron H.....821 Granite Building, Rochester, 1892
Adams, R. A.....46 N. Fitzhugh, Rochester, 1899
Adriance, F. W.....306 Lake, Elmira, 1883
Allan, Arthur G.....8 W. 49th, New York, Mhn., 1895
Allen, Emma T. P.....310 Clermont Ave., New York, Bkn., 1899
Allen, Herbert C.....310 Clermont Ave., New York, Bkn., 1899
Allen, Paul.....3 E. 48th, New York, Mhn., 1892
Allen, T. F.....3 E. 48th, New York, Mhn., 1879
Ambler, J. Edgar.....114 W. 80th, New York, Mhn., 1893
Andrews, B. P.....Dansville, 1893
Arthur, Daniel H.....Collins State Hospital, Gowanda, 1891
Ashley, M. C.....Middletown, 1894
Austin, Edson C.....Elkhorn, Wis., 1896
Avery, E. W.....16 Hancock, New York, Bkn., 1889
Babbitt, Otis H.....178 Genesee, Auburn, 1892
Bachman, G. A.....167 South Ave., Rochester, 1893
Baker, Jennie v. H.....512 Bedford Ave., New York, Bkn., 1889
Baldwin, G. E.....500 University Ave., Syracuse, 1898
Baldwin, Jared G.....8 E. 41st, New York, Mhn., 1894
Ball, Halsey J.....Scott, 1891

Barkeloo, Harriet	915 Third Ave., New York, Bkn.,	1889
Barnard, J. S	2112 N. Charles St., Baltimore, Md.,	1886
Barnes, Charles F	Weedsport,	1893
Barnes, Frank H	Stamford, Ct.,	1896
Barrus, Clara	Middletown,	1894
Baylies, B. L'B	418 Putnam Ave., New York, Bkn.,	1883
Beals, Herbert	176 Franklin, Buffalo,	1899
Beebe, C. E	3 W. 37th, New York, Mhn.,	1888
Bell, Willard N	6 Greene, Ogdensburgh,	1890
Bennet, G. H. R	21 S. Portland Ave., New York, Bkn.,	1889
Benson, R. F., Jr	2 St. Paul Pl., Troy,	1886
Berghaus, Alex	138 E. 65th, New York, Mhn.,	1888
Besemer, Martin	40 S. Albany, Ithaca,	1897
Best, F. W	66 Ball, Port Jervis,	1893
Beyea, J. L	217 Second Ave., New York, Mhn.,	1894
Bierbauer, Bruno W	85 Pierrepont, New York, Bkn.,	1898
Birch, Chas. E	White Plains,	1894
Birdsall, Wm. G	Clintondale,	1894
Birdsall, S. T	80 Ridge, Glens Falls,	1883
Birdsall, T. P	Patterson,	1892
Bishop, F. M	Newark Valley	1891
Bishop, W. H	46 W. 48th, New York, Mhn.,	1893
Bissell, E. J	75 S. Fitzhugh, Rochester,	1889
Blackman, W. W	519 Clinton Ave., New York, Bkn.,	1890
Bleecker, Wm. H	Riverhead,	1892
Bolan, L. W	413a Quincy, New York, Bkn.,	1890
Bond, Mary E	965 Flatbush Ave., New York, Bkn.,	1892
Boocock, R	122 Lexington Ave., New York, Mhn.,	1894
Bonnell, Chas. L	3 Hanson Pl., New York, Bkn.,	1879
Borden, G. T	Caledonia,	1887
Boyle, Chas. C	49 W. 37th, New York, Mhn.,	1888
Boynton, F. H	36 W. 50th, New York, Mhn.,	1888
Brainard, L. L	2 Cronkhite Block, Little Falls,	1883
Brinkman, Mary A	Brewster,	1891
Brown, E. V	N. Tarrytown,	1886
Brown, M. Belle	135 W. 34th, New York, Mhn.,	1892
Bryan, E. W	Corning,	1880
Bruce, A. H	Wolcott,	1896
Bryant, Wm. C	64 Greene Ave., New York, Bkn.,	1899
Buchholz, Louise Z	73 E. 8th, New York, Mhn.,	1892
Buell, E. S. (Lic.)	South Greece,	1893
Buell, Jesse W	61 Clinton Ave., S., Rochester,	1889
BULLARD, D. H. (1887)	Glens Falls,	1864
Bulmer, Geo. W	1210 Bushwick Ave., New York, Bkn.,	1891
Burdick, Mrs. Alice H	341 W. 34th, New York, Mhn.,	1892
Burnham, Clark	182 Clinton, New York, Bkn.,	1889
Butler, Wm. M	507 Clinton Ave., New York, Bkn.,	1881
Caldwell, Frank E	151 Henry, New York, Bkn.,	1889
Calisch, Alex. C	55 W. Bridge, Oswego,	1896
Candee, J. W	501 Fayette Park, Syracuse,	1885

Carleton, Bukk G.	75 W. 50th, New York, Mhn.,	1892
Carroll, S. H.	223 State, Albany,	1874
Case, Walter R.	239 Mill, Poughkeepsie,	1886
Cassidy, Georgia A.	703 Nostrand Ave., New York, Bkn.,	1891
Chadwick, John G.	262 Delaware Ave., Buffalo,	1899
Chamberlin, W. T.	Brooklyn Hom. Hospital, New York,	1899
Chandler, D. Henry		1894
Chapin, Edward	21 Schermerhorn, New York, Bkn.,	1883
Charles, Emily C.	51 W. 127th, New York, Mhn.,	1898
Chase, J. Oscoe	214 E. 53d, New York, Mhn.,	1888
Church, Eloise I.	41 W. 94th, New York, Mhn.,	1896
Church, Geo. H. (Lic.)	Oak's Corners,	1891
Church, H. A.	601 Warren, Syracuse,	1898
Clark, Byron G.	162 W. 122d, New York, Mhn.,	1891
Clark, F. W.	Williamson,	1891
Clark, L. A.	Cambridge,	1879
Coburn, Edward S.	94 Fourth, Troy,	1874
Cole, D. D.	Batavia,	1883
Collins, N. M.	43 East Ave., Rochester,	1886
Cook, C. P.	Hudson,	1872
Cook, J. T.	636 Delaware Ave., Buffalo,	1883
Cooke, Mrs. H. N. F.	41 W. 65th, New York, Mhn.,	1892
Cooper, C. S.	Skaneateles,	1896
Cornell, C. W.	W. 72d & Boulevard, New York, Mhn.,	1884
Corwin, Elizabeth	104 Main, Binghamton,	1892
COUCH, ASA S. (1894)	Fredonia,	1864
Covert, N. B.	Geneva,	1878
Covert, Rynear B.	Seneca Falls,	1892
Cox, Edward G.	109 State, Albany,	1894
Cox, F. J.	109 State, Albany,	1894
Cox, G. A.	80 S. Swan, Albany,	1878
Crandall, E. L.	78 Fourth, Troy,	1885
Danforth, L. L.	59 W. 52d, New York, Mhn.,	1888
Davis, J. E. L.	743 Madison Ave., New York, Mhn.,	1891
Deady, Charles	110 W. 48th, New York, Mhn.,	1888
Deady, H. P.	Liberty,	1899
Dean, L. W.	Waterville,	1899
Dearborn, H. M.	146 W. 57th, New York, Mhn.,	1888
Decker, W. M.	97 W. Genesee, Buffalo,	1883
De La Barre, W. C.	224 W. 59th, New York, Mhn.,	1894
Demarest, J. H.	1969 Madison Ave., New York, Mhn.,	1892
Denison, R. N.	55 Eighth Ave., New York, Bkn.,	1899
Denslow, M. H.	Marbledale, Conn.,	1894
Deschere, Martin	334 W. 58th, New York, Mhn.,	1889
Deuel, W. Estus	Chittenango,	1891
Dillingham, T. M.	8 W. 49th, New York, Mhn.,	1891
Dillow, George M.	57th and Broadway, New York, Mhn.,	1889
Doane, W. H.	Pittsford,	1893
Doty, G. H.	245½ Cumberland, New York, Bkn.,	1892
Doughty, Francis E.	512 Madison Ave., New York, Mhn.,	1877

Dowe, F. Le C.	332 Alexander Ave., New York, Mhn.,	1892
Dowling, J. W.	8 W. 45th, New York, Mhn.,	1889
Dreyer, F. H.	Webster Ave., Fordham, N. Y., Mhn.,	1895
Du Bois, W. C.	519 S. Salina, Syracuse,	1893
Dutcher, M. T.	Owego,	1884
Eddy, Ermina C.	500 William, Elmira,	1883
Eife, A. F.	175 W. 10th, New York, Mhn.,	1888
Eisenbrey, E. H.	Gloversville,	1897
Elliott, Amos H.	480 Monroe, New York, Bkn.,	1890
Erb, Peter	32 Palace Arcade, Buffalo,	1891
Eurich, C.	349 E. 85th, New York, Mhn.,	1888
Fancher, E.	16 Orchard, Middletown,	1885
Faust, Fred A.	60 Market, Poughkeepsie,	1893
Faust, Louis	19 Jay, Schenectady,	1885
Faust, Wm. P.	29 Jay, Schenectady,	1898
Fay, R. P.	165 Warburton Ave., Yonkers,	1892
Ferrier, James	166 E. 111th, New York, Mhn.,	1896
Fiske, Wm. M. L.	484 Bedford Ave., New York, Bkn.,	1875
Fiske, E. Rodney	488 Nostrand Ave., New York, Bkn.,	1896
Follet, W. M.	Seneca Falls,	1891
Foster, E. Agate	Patchogue,	1891
Foster, Henry	Clifton Springs,	1891
Foster, H. A.	3 St. John's Pl., Buffalo,	1891
Foster, W. E.	Glen Cove,	1892
Fowler, W. P.	63 Clinton Ave., S., Rochester,	1876
Fralick, W. G.	778 Madison Ave., New York, Mhn.,	1892
Francisco, D. E.	Middletown,	1897
Franklin, E. D.	331 W. 14th, New York, Mhn.,	1888
Frazer, F. M.		1894
Frazier, L. A.	124 Division, Amsterdam,	1892
Frye, M. M.	167 Genesee, Auburn,	1884
Garnsey, W. S.	77 N. Main, Gloversville,	1888
Garrison, J. B.	111 E. 70th, New York, Mhn.,	1888
Getman, A. D.	17 Ford Ave., Oneonta,	1893
Gifford, G. L.	Hamilton,	1868
Gifford, W. B.	Attica,	1886
Gillespie, Lizzie S.		1889
Gillette, Myra A.	Medina,	1891
Givens, A. J.	Stamford, Conn.,	1891
Goodrich, S. W.	507 W. 152d, New York, Mhn.,	1894
Gore, Jennie E.	1145 Park Ave., New York, Mhn.,	1892
Gorham, G. E.	160 Hamilton, Albany,	1883
Gorton, D. A.	174 Clinton, New York, Bkn.,	1890
Graham, M. E.	10 Jones Ave., Rochester,	1893
Greene, C. R. F.	Mount Kisco,	1894
Greenleaf, J. T.	Owego,	1884
Gregory, G. W.	370 W. Church, Elmira,	1895
Gridley, G. L.	605 Warren, Syracuse,	1895
GUERNSEY, EGBERT (1899)	180 W. 59th, New York, Mhn.,	1865
GULICK, WILLIAM (1885).	Watkins,	1865

Gwynn, Charles A.	13 Grover, Auburn,	1899
Hadley, C. H.	58th and 13th Ave., New York, Bkn.,	1891
Haines, C. T.	Whitesboro,	1891
Hall, M. J.	Mamaroneck,	1893
Hallock, J. H.	Saranac Lake,	1880
Hamlin, F. W.	130 W. 48th, New York, Mhn.,	1892
Hartley, W. G.	345 W. 34th, New York, Mhn.,	1891
Hartman, W. L.	601 Warren, Syracuse,	1893
Hasbrouck, E.	369 Ninth, New York, Bkn.,	1873
Hasbrouck, Joseph	Dobb's Ferry,	1899
Hasbrouck, Sayer	117 Broad, Providence, R. I.,	1883
Hathaway, H. S.	146 W. 92d, New York, Mhn.,	1892
Haviland, N. H.	Fulton,	1880
Hawley, H. Reed	Staatsburgh,	1897
Hawley, L. B.	Clyde,	1893
Haywood, Chas. W.	Stamford, Conn.,	1898
Haywood, George M.	48 Clinton Ave., S., Rochester,	1890
Haywood, Mrs. Julia F.	612 West Ave., Rochester,	1890
Helfrich, C. H.	542 Fifth Ave., New York, Mhn.,	1888
Helmuth, William Tod.	504 Fifth Ave., New York, Mhn.,	1873
Helmuth, W. T., Jr.	465 Lexington Ave., New York, Mhn.,	1888
Heinemann, J. D.	77 E. Eagle, Buffalo,	1887
Hibbard, D. M.	112 Berry, Olean,	1893
Hill, Emily L.	Gloversville,	1899
Hinman, E. L.	84 W. Oneida, Oswego,	1898
Hodge, W. H.	8 Gluck Block, Niagara Falls,	1895
Honan, W. F.	W. 71st & Gr'nd Boulev'd, N. Y., Mhn.,	1894
Hopkins, W. W.	Geneva,	1894
Horton, E. T.	Whitehall,	1897
Hough, W. D.	Niagara Falls,	1891
Houghton, Henry C.	7 W. 39th, New York, Mhn.,	1875
Howe, J. M.	58 W. 47th, New York, Mhn.,	1894
Howland, R. B.	306 Lake, Elmira,	1897
Hoyt, E. F.	39 W. 58th, New York, Mhn.,	1894
Hoyt, Gordon W.	808 Madison, Syracuse,	1898
Hoyt, H. W.	75 S. Fitzhugh, Rochester,	1893
Hoyt, Mrs. Mary M.	10 Westminster Road, Rochester,	1893
Hrdlicka, Ales	106 E. 71st St., New York, Mhn.,	1894
Hunt, Dwight B.	159 Madison Ave., New York, Mhn.,	1887
Hunt, Oren G.	205 E. 19th, New York, Mhn.,	1891
HUNTING, NELSON (1897)	155 Hamilton, Albany,	1872
Hurd, S. Wright	78 Main, Lockport,	1891
Hutchins, H. S.	Batavia,	1870
Hyde, L. D.	Glenmary, Owego,	1894
Jacobson, Frank A.	269 Grand, Newburgh,	1891
Jeffery, George C.	343 Jefferson Ave., New York, Bkn.,	1887
Jenkins, George H.	Binghamton,	1897
Johnston, C. L.	467 Vanderbilt Ave., New York, Bkn.,	1890
Kaple, Edward B.		1897
Kastendieck, J. T. W.	149 Keap, New York, Bkn.,	1890

Keator, Bruce S.	Asbury, Park, N. J.,	1894
Keegan, Wm. A.	44 Clinton Ave., S., Rochester,	1890
Keese, J. Mumford	211 Schonnard, Syracuse,	1899
Keith, Horace G.	107 S. Broadway, Yonkers,	1895
Kellogg, Chas. M.	38 Clinton Ave., N., Rochester,	1889
KELLOGG, E. M. (1894)	115 E. 37th, New York, Mhn.,	1866
Kenyon, W. B.	13 E. Swan, Buffalo,	1883
King, Wm. Harvey	64 W. 51st, New York, Mhn.,	1886
Kingsley, O. D.	White Plains,	1897
Kinne, A. B.	Fayette Park, Syracuse,	1882
Kinney, C. Spencer	Middletown,	1883
Kinne, E. O.	516 Warren, Syracuse,	1899
Klots, E. D.	156 W. 48th, New York, Mhn.,	1899
Knapp, James C.	Geneva,	1892
Laidlaw, Alexander H.	137 W. 41st, New York, Mhn.,	1897
Laidlaw, Geo. F.	137 W. 41st, New York, Mhn.,	1894
Laird, F. F.	236 Genesee, Utica,	1883
Land, Joseph F.	130 W. 126th, New York, Mhn.,	1888
Lane, Charles E.	289 Mill, Poughkeepsie,	1893
Lane, Irwin J.	2 Church, Sing Sing,	1892
Lannin, Louise	148 W. 85th, New York, Mhn.,	1895
Latimer, W. C.	351a Clinton, New York, Bkn.,	1884
Lauer, C. F.	248 Emerson Pl., Mhn., Bkn.,	1891
Lawrence, J. B.	289 Ninth, New York, Bkn.,	1894
Leach, Albert E.	Mount Morris,	1893
Leal, Malcolm	107 W. 48th, New York, Mhn.,	1888
Lee, J. M.	121 Lake Ave., Rochester,	1884
Leonard, Wm. H.	Tully,	1899
LeSeur, John W.	207 E. Main, Batavia,	1890
Lewis, Fred D.	188 Franklin, Buffalo,	1893
Lewis, F. Edward	Cambridge,	1891
Lewis, F. Park	454 Franklin, Buffalo,	1881
Livezey, F. B.	2807 N. Broad, Philadelphia, Pa.,	1898
Lount, Robert	79 Fulton, Hempstead,	1893
Low, E. C.	Plattsburgh,	1878
MacCallum, John H.	404 Monroe Ave., Rochester,	1890
Macfarland, R. L.	53 Clinton Ave., New York, Jamaica,	1898
MacMaster, Mrs. M.		1894
Macy, C. S.	117 W. 12th, New York, Mhn.,	1895
Madden, J. D.	Sing Sing,	1892
Martin, L. A.	74 Exchange, Binghamton,	1892
Martin, T. J.	145 North, Buffalo,	1891
Maycock, B. J.	33 Allen, Buffalo,	1893
McCrea, P. A.	18 West Eagle, Buffalo,	1891
McDonald, W. O.	117 W. 44th, New York, Mhn.,	1894
McDowell, Chas.	116 W. 13th, New York, Mhn.,	1888
McDowell, Geo. W.	136 W. 130th, New York, Mhn.,	1892
McGraw, D. H.	96 Court, Binghamton,	1899
McKown, W. J.	335 Hamilton, Albany,	1895
McMichael, A. R.	969 Madison Ave., New York, Mhn.,	1891

McMichael, D. A.	67 W. 96th, New York, Mhn.,	1892
McPherson, P. J.	Millport,	1899
Merriam, H. E.	Owego,	1894
Meyer, O. N.	171 E. 78th, New York, Mhn.,	1896
Milbank, W. E.	111 State, Albany,	1879
Miller, C. J.	Mount Kisco,	1894
Miller, John	48 St. John's Pl., Buffalo,	1891
MILLER, R. E. (1898)	Oxford,	1871
Minton, H. B.	165 Joralemon, New York, Bkn.,	1888
Mitchell, J. J.	242 Montgomery, Newburg,	1880
Moffat, John L.	17 Schermerhorn, New York, Bkn.,	1883
Montanye, W. De la	Rondout, Kingston,	1891
Moseley, G. T.	202 Delaware Ave., Buffalo,	1891
Mossman, N. A.	28 E. 47th, New York, Mhn.,	1892
Mott, O. H. (Lic.)	Fort Ann,	1897
MULL, P. W. (1896)	Ghent,	1876
Muncie, E. H.	119 Macon, New York, Bkn.,	1890
Muncie, Libbie H.	119 Macon, New York, Bkn.,	1896
Musits, H. von	47 E. 83d, New York, Mhn.,	1892
Nead, W. M.	210 State, Albany,	1891
Neefus, P. Wyckoff	124 East Ave., Rochester,	1896
Neilson, H. S.	46 W. 48th, New York, Mhn.,	1896
Nickelson, W. H.	Adams,	1889
Noble, E. H.	410 E. Church, Elmira,	1894
Norton, A. B.	16 W. 45th, New York, Mhn.,	1886
Nott, F. J.	29 E. 55th, New York, Mhn.,	1891
O'Connor, J. T.	29 W. 45th, New York, Mhn.,	1889
Ogden, E. G.	551 West End Ave., New York, Mhn.,	1894
Ogden, G. S.	24 Kenilworth Pl., New York, Bkn.,	1898
Ostrander, P. M.	Nunda,	1894
Ostrom, H. I.	42 W. 48th, New York, Mhn.,	1886
Otis, C. F.	Honeoye Falls,	1890
Otis, J. C.	Poughkeepsie,	1883
Page, Roy A.	Geneseo,	1895
Paige, H. W.	256 W. 57th, New York, Mhn.,	1892
PAINE, H. M. (1891)	Glens Falls,	1850
Palmer, A. Worrall	138 W. 81st, New York, Mhn.,	1899
Parsons, Thomas	33 Clinton Ave., S., Rochester,	1896
Partridge, B. S.	East Bloomfield,	1889
Pearsall, J. A.	Saratoga Springs,	1882
Pearsall, W. S.	128 W. 78th, New York, Mhn.,	1896
Pease, C. G.	101 W. 72d, New York, Mhn.,	1891
Pettet, Isabella M.	308 E. 15th, New York, Mhn.,	1897
Pettit, A. R.	Patchogue,	1891
Phillips, R. Oliver	Yonkers,	1891
Phillips, R. E.	21 Park Ave., Rochester,	1898
Pierce, Willard Ide	64 W. 126th, New York, Mhn.,	1890
Pierron, H. J.	438 Greene Ave., New York, Bkn.,	1890
Pierson, W. H.	101 McDonough, New York, Bkn.,	1891
Porter, E. H.	181 W. 73d, New York, Mhn.,	1888

Potter, Clarence A.....	Gowanda State Hom. Hospital,	1899
Powelson, A. P.....	Middletown,	1897
PRATT, L. M. (1886)....	Homer,	1864
Preston, H. G.....	54 Greene Ave., New York, Bkn.,	1875
Proctor, W. H.....	25 Main, Binghamton,	1884
Purdy, M. S.....	Corning,	1887
Queen, L. A.....	114 W. 85th, New York, Mhn.,	1891
Rabe, F. E.....	227 W. 42d, New York, Mhn.,	1892
Radway, C. W.....	Mexico,	1885
Rambo, W. S.....	41 Sophia, Rochester,	1893
Reynolds, W. U.....	320 Manhattan Ave., New York, Mhn.,	1888
Richardson, A. J.....	39 E. 83d, New York, Mhn.,	1891
Richardson, G. W.....	138 E. 79th, New York, Mhn.,	1891
Ricker, Mrs. M. S.....	58 Lorimer, Rochester,	1890
Rieger, Joseph.....	404 Central Ave., Dunkirk,	1899
Ritch, A. M.....	711 Putnam Ave., New York, Bkn.,	1891
Ritch, Orando S.....	337a Macon, New York, Bkn.,	1889
Ritchie, F. G.....	131 W. 47th, New York, Mhn.,	1894
Roberts, D. J.....	New Rochelle, New York,	1889
Roberts, G. W.....	Broadway and 52d, New York,	1891
Robinson, N.....	89 Halsey, New York, Bkn.,	1890
Rockefeller, H. O.....	152 Jerome, New York, Bkn.,	1892
Rodgers, Albert H.....	Corning,	1898
Roe, J. F.....	25 Main, Binghamton,	1897
Rounds, W. E.....	154 W. 47th, New York, Mhn.,	1889
Rowley, C. A.....	Victor	1890
Royal, T. C.....	Ballston Spa,	1888
Rudderow, E. D.....	233 W. 83d, New York, Mhn.,	1896
Russell, H. Everett.....	30 E. 74th, New York, Mhn.,	1892
Russell, J. E.....	1036 Bedford Ave., New York, Bkn.,	1889
Sanders, L. J.....	421 Monroe Ave., Rochester,	1897
Santway, F. L.....	Theresa,	1896
Schenck, H. D.....	241 McDonough, New York, Bkn.,	1887
Schley, J. M.....	32 W. 49th, New York, Mhn.,	1889
Schumann, C.....	Delhi,	1892
Scott, W. H.....	104 W. 44th, New York, Mhn.,	1888
Scudder, N. C.....	506 N. James, Rome,	1898
SEARLE, W. S. (1894)...	62 Clark, New York, Bkn.,	1865
Seitz, F. B.....	33 N. Pearl, Buffalo,	1897
Severance, B. W.....	Gouverneur,	1897
Seward, F. W.....	Goshen,	1891
Seymour, G. W.....	Westfield,	1883
Shattuck, J. W. M.....	Westport,	1897
Shaw, J. C.....	Hoosick Falls,	1885
Sheldon, Jay W.....	501 Fayette Park, Syracuse,	1885
Shelton, G. G.....	521 Madison Ave., New York, Mhn.,	1886
Shepard, G. A.....	Broadway and 52d, New York, Mhn.,	1892
Shepard, Jessie.....	21 Irving Place, Buffalo,	1891
Sherman, I. P.....	114 W. 44th, New York, Mhn.,	1894
Simmons, D.....	1188 Dean, New York, Bkn.,	1884

Simmons, R. S.	129 E. 59th, New York, Mhn.,	1891
Simmons, Silas S.	Susquehanna, Penn.,	1885
Simpson, E. D.	320 W. 115th, New York, Mhn.,	1899
Skinner, S. W.	Le Roy,	1887
Slaught, J. E.	Warsaw,	1883
Smith, F. R.	400 Main, E., Rochester,	1893
SMITH, HENRY M. (1895)	288 St. Nicholas Av., New York, Mhn.,	1866
Smith, O. W.	Union Springs,	1884
Smith, St. Clair	25 W. 50th, New York, Mhn.,	1891
SMITH, T. F. (1894)	264 Lenox Ave., New York, Mhn.,	1871
Snow, S. R.	267 Alexander Ave., Rochester,	1893
Snyder, E. E.	27 Main, Binghamton,	1883
SOUTHWICK, A. B. (1898)	Rome,	1871
Southwick, D. E.	Ogdensburgh,	1867
Spencer, T. D.	24 Union, S., Rochester,	1884
Spire, C. E.	Clyde,	1898
Spoor, D. E.	N. Granville,	1883
Stanton, L. M.	132 W 58th, New York, Mhn.,	1895
Stearns, G. R.	201 Linwood Ave., Buffalo,	1893
Stephens, C. E.		1893
Stevens, D. D.	170 W. 54th, New York, Mhn.,	1894
Stewart, J. A.	1030 Bedford Ave., New York, Bkn.,	1892
Stewart, W. A.		1895
Stiles, H. R.	F. Humphrey & Son, New York, Mhn.,	1885
Storer, J. H.	30 Edgecomb Ave., New York, Mhn.,	1892
Street, H. E.	98 Brooklyn Ave., New York, Bkn.,	1894
Strong, C. H.	Cleveland, O.,	1892
Stumpf, D. B.	631 Ellicott, Buffalo,	1885
Sumner, C. R.	33 Clinton Ave., S., Rochester,	1882
Sweeting, W. H.	Savannah,	1890
Swett, Emily F.	Medina,	1892
Swift, E. P.	Pleasantville,	1888
Talcott, Seldon H.	Middletown,	1874
Talmage, S.	22 Schermerhorn, New York, Bkn.,	1899
Teets, C. E.	37 W. 39th, New York, Mhn.,	1888
Terry, M. O.	196 Genesee, Utica,	1876
Thatcher, E. P.	Main St., Newark,	1893
Thompson, V.	56 W. 21st, New York, Mhn.,	1888
Throop, A. P.	Port Gibson,	1874
Thurber, T. J.	157 Plymouth Ave., Rochester,	1889
Townsend, Irving	67 W. 46th, New York, Mhn.,	1891
Trotter, R. R.	Yonkers,	1890
Turner, T. S.	231 Chenango, Binghamton,	1897
Tuttle, E. G.	61 W. 51st, New York, Mhn.,	1892
Tytler, G. E.	113 W. 126th, New York, Mhn.,	1889
Valentine, R. K.	190 Lincoln Pl., New York, Bkn.,	1891
Van Buren, B. L. (Lic.)	Lebanon Springs,	1897
Van Buren, Hattie C.	163 Halsey, New York, Bkn.,	1895
Van Denburg, M. W.	Mount Vernon,	1887
Van den Burg, W. H.	32 W. 49th, New York, Mhn.,	1897

Van Derwerker, H. W..	Sandy Hill,	1897
Van Loon, A. B.....	50 Eagle, Albany,	1894
Van Ostrand, D. G.....	Candor,	1899
Vehslage, S. H.....	117 W. 43d, New York, Mhn.,	1891
Vincent, Stanley.....	262 Main, Catskill,	1899
Von der Lühe, A.....	245 Hooper, New York, Bkn.,	1883
Waldo, H. L.....	1834 Fifth Ave., Troy,	1879
Walker, C. E.....	West Henrietta,	1887
Walrad, C. B.....	Johnstown,	1889
Ward, C. A.....	33 Court, Binghamton,	1890
Warner, A. G.....	194 Schermerhorn, New York, Bkn.,	1888
Warner, F. P.....	Canandaigua,	1893
WATSON, W. H. (1891)..	270 Genesee, Utica,	1869
Wetmore, J. McE.....	41 E. 29th, New York, Mhn.,	1892
White, A. Lenora.....	151 W. 46th, New York, Mhn.,	1892
White, J. C.....	Portchester,	1891
Wiggins, T. C.....	76 Macon, New York, Bkn.,	1894
Wilcox, DeWitt G.....	173 Lexington Ave., Buffalo,	1887
Wilcox, Sidney F.....	51 W. 52d, New York, Mhn.,	1891
Williams, F. F.....	6 Goodrich, Canton,	1892
Williams, T. C.....	118 E. 19th, New York, Mhn.,	1889
Williamson, B.....	Friendship,	1893
Willis, H., Jr.....	1303 Dean, New York, Bkn.,	1892
Winchell, W. B.....	137 Berkeley Pl., New York, Bkn.,	1889
Wolcott, E. H.....	57 Union, S., Rochester,	1886
Woodruff, A. J.....	Babylon,	1891
WRIGHT, A. R. (1894)...	414 Elmwood Ave., Buffalo,	1863
Zwetsch, J. D.....	Gowanda,	1883

DELEGATE MEMBERS.

CLASS A.

Terms expire with the Annual Meeting in 1900.

New York County, 35—Allen, J. Wilford, 110 W. Twelfth.
Andrew, R. M., 1777 Bathgate Ave.
Arschagouni, John, 743 Lexington Ave.
Bagg, C. L., 67 W. 45th.
Bickford, Lydia A., 45 W. 39th.
Brown, Granville C., 56 W. 45th.
Buchanan, T. D., 328 W. 24th.
Crump, W. G., 693 Madison Ave.
Dunlevy, Rita, 328 W. 57th.
Edwards, Mary L., 19 W. 46th.
Hallett, G. DeWayne, 107 W. 82d.
Hart, A. H., 130 W. 44th.
Hiller, J. L., 110 W. 82d.
du Jardin, Roland, 129 E. 76th.

Jarrett, Elizabeth, 159 W. 48th.
Keatinge, Harriette d'E., 119 W. 48th.
Maeder, J. G., 304 E. 120th.
Morgenthaler, Sophia, 131 W. 64th.
Munson, Edwin S., 16 W. 45th.
Nutter, Mary E., 144 Lexington Ave.
O'Brien, Evelina C. D., 226 E. 87th.
Palmer, J. B., 201 E. 23d.
Patchen, George H., 11 E. 59th.
Schroeder, Marie O., 1744 Amsterdam Ave.
Seward, J. Perry, 113 W. 85th.
Sheldon, Floyd P., 223 W. 122d.
Sherman, Leroy B., 355 W. 14th.
Simonson, J. T., 46 W. 85th.
Stewart, G. T., Metropolitan Hospital.
Townsend, Chas. W., 144 W. 46th.
Townsend, Katherine G., 354 W. 123d.
Wait, Phebe J. B., Ninth Ave. and 34th.
Whitehorne, F. N., 64 W. 126th.
Worrall, M. Ruth, 239 W. 44th.
Wright, Amelia, 5 W. 82d.

CLASS B.

Terms expire with the Annual Meeting, 1901.

Broome County, 2—Bailey, D. P., 41 Court, Binghamton.

Dutchess County, 2—Otis, John H., Poughkeepsie.
Angel, Milton, Salt Point.

Jefferson County, 2—

Monroe County 4—Chamberlayne, Louise F., 28 Emerson. Rochester.
Carman, W. B., 23 Upton Park, Rochester.
Tretton, J. K., 239 Lake Ave., Rochester.
Tubbs, J. F., Fairport.

Oswego County, 2—Richards, L. B., E. Bridge, Oswego.

Westchester County, 3—Ives, N. H., Mt. Vernon.
Mason, P. H., Peekskill.
Nutting, N., Mt. Vernon.

CLASS C.

Terms expire with the Annual Meeting, 1902.

Kings County, 12—Aten, W. H., 83 Greene Ave.
Brooklyn. Ayres, Rebecca J., 509 Van Buren.
Bedford, E. R., 153 Tompkins Ave.,
Broughton, L. D., Jr., 418 Madison.
Buys, T. L., 1483 Bedford Ave.

Cameron, Elizabeth W. M., 23 Seventh Ave.
Clarke, M. Elizabeth, 8 Lafayette Ave.
Cort, Lottie A., 89 Division Ave.
Devol, E., 114 Milton.
Fawdray, J. W., 242 Clermont Ave.
Iler, G. H., 237 McDonough.
Lazarus, G. F., 6 Caton Ave.
Love, W. L., 1188 Dean.
McLenathan, W. H., 101 Division Ave.
Moon, W. W., 184 Macon.
Palmer, G. Howard, 90 Hancock.
Rink, W. S., 295 Halsey.
Shrewsbury, W. J., 238 Keap.
Stolz, Rosalie H., 778 Putnam Ave.
Underhill, A. E., 465 Hancock.
Walmsley, R. F., 491 Putnam Ave.

CLASS D.

Terms expire with the Annual Meeting in 1903.

Albany County, 4—Blessing, E. A., 93 Hudson Ave., Albany.
Cochrane, H. D., Hom. Hospital, Albany.

Chenango County, 1—Ganow, G. J., Oxford.

Madison County, 1—

Montgomery County, 1—Knott, Harriet A., Gloversville.

Onondaga County, 4—Chaffee, R. W., 1701 Genesee, Syracuse.
Keeler, E. E., 452 Salina, Syracuse.
Lukens, C. M., 117 E. Jefferson, Syracuse.

Ontario County, 1—Mitchel, C. T., Canandaigua.

Seneca County, 1—Peterson, O. W., Waterloo.

DIRECTORY

OF THE

HOMŒOPATHIC PRACTITIONERS

OF THE

STATE OF NEW YORK.

DECEMBER, 1899.

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* Permanent Member of State Society.
† Delegate Member of State Society.
‡ Member of County Society.

In accordance with the wishes of the American Institute of Homœopathy notice of good openings for homœopathists are solicited and will be published.

The thanks of the Society are due (and are hereby acknowledged) to those who have afforded aid in the compilation of this Directory.

All who notice errors will confer a favor upon the profession at large by promptly sending corrections and additions to

JOHN L. MOFFAT,
Secretary.

17 Schermerhorn Street,
Brooklyn, New York.

The directory this year shows 1266 homœopathic doctors in 322 towns of 59 counties, distributed as follows:

‡Albany	18	‡Jefferson	20	Rockland	3
Allegany	6	‡Kings	203	St. Lawrence	14
‡Broome	22	Lewis	2	Saratoga	11
Cattaraugus	8	Livingston	10	Schenectady	5
Cayuga	15	‡Madison	13	Schoharie	0
Chautauqua	16	‡Monroe	77	Schuyler	3
Chemung	11	‡Montgomery	5	‡Seneca	8
‡Chenango	6	Nassau	2	Steuben	13
Clinton	1	‡New York	329	Suffolk	10
Columbia	8	Niagara	16	Sullivan	1
Cortland	9	Oneida	21	Tioga	9
Delaware	5	‡Onondaga	41	Tompkins	12
‡Dutchess	15	‡Ontario	16	Ulster	11
Erie	61	Orange	30	Warren	6
Essex	9	Orleans	8	Washington	13
Franklin	2	‡Oswego	11	Wayne	20
Fulton	7	Otsego	8	‡Westchester	34
Genesee	10	Putnam	3	Wyoming	9
Greene	3	Queens	7	Yates	3
Hamilton	0	Rensselaer	20		
Herkimer	3	Richmond	4		

‡County Society.

TOWN INDEX.

Town.	County.
Adams	Jefferson
Akron	Erie
Albany	Albany
Albion	Orleans
Alexandria Bay	Jefferson
Amsterdam	Montgomery
Antwerp	Jefferson
Arcade	Wyoming
Attica	Wyoming
Auburn	Cayuga
Babylon	Suffolk
Baldwinsville	Onondaga
Ballston Spa	Saratoga
Batavia	Genesee
Batchellerville	Saratoga
Bath	Steuben
Bay Shore	Suffolk
Belfast	Allegany
Belmont	Allegany
Big Flats	Chemung
Binghamton	Broome
Boonville	Oneida
Brewster	Putnam
Briar Hill	St. Lawrence
Brighton	Monroe
Brockport	Monroe
Brooklyn	Kings
Brownville	Jefferson
Buffalo	Erie
Caledonia	Livingston
Cambridge	Washington
Canandaigua	Ontario
Candor	Tioga
Canisteo	Steuben
Canoga	Seneca
Canton	St. Lawrence
Cape Vincent	Jefferson
Carthage	Jefferson
Castleton	Rensselaer
Catlin	Chemung
Cazenovia	Madison
Chatham	Columbia

Chittenango ..... Madison
Clarendon ..... Orleans
Clayville ..... Oneida
Clifton Springs.....Ontario
Clinton..... Oneida
Clintondale ..... Ulster
Clyde ..... Wayne
Cohoes ..... Albany
Conklin Center.....Broome
Cooperstown ..... Otsego
Copenhagen ..... Lewis
Coxsackie ..... Greene
Corfu ..... Genesee
Corning ..... Steuben
Cortland ..... Cortland
Crown Point.....Essex
Cuba ..... Allegany
Dansville ..... Livingston
Deansboro ..... Oneida
De Kalb Junction..St. Lawrence
Delhi ..... Delaware
Deposit ..... Broome
De Ruyter..... Madison
Dobb's Ferry..... Westchester
Dunkirk ..... Chautauqua
Eagle Bridge..... Rensselaer
Earlville.....Madison
East Aurora ..... Erie
East Bloomfield ..... Ontario
East Greenbush ..... Rensselaer
East Hamilton..... Madison
East Hamlin ..... Monroe
Easton ..... Washington
Elba ..... Genesee
Elbridge ..... Onondaga
Elizabethtown ..... Essex
Ellenville ..... Ulster
Elmira ..... Chemung
Essex ..... Essex
Etna ..... Tompkins
Fairport ..... Monroe
Farmer Village..... Seneca
Fayetteville ..... Onondaga
Fishkill-on-Hudson ... Dutchess
Flushing ..... Queens
Fonda ..... Montgomery
Fort Ann.....Washington
Fort Edward.....Washington
Fort Plain.....Montgomery
Franklin ..... Delaware
Fredonia ..... Chautauqua
Friendship ..... Allegany
Fulton ..... Oswego
Galway ..... Saratoga
Gasport ..... Niagara
Geneseo ..... Livingston
Geneva ..... Ontario
Ghent ..... Columbia
Glen Cove.....Nassau
Glens Falls.....Warren
Gloversville ..... Fulton
Goshen ..... Orange
Gouverneur ..... St. Lawrence
Gowanda ..... Cattaraugus
Granville ..... Washington
Greenbush ..... Rensselaer
Greene ..... Chenango
Greenport ..... Suffolk
Greenwich ..... Washington
Groton ..... Tompkins
Hamilton ..... Madison
Hammondsport ..... Steuben
Hartwick ..... Otsego
Hempstead ..... Nassau
Herkimer ..... Herkimer
Heuvelton ..... St. Lawrence
Holland ..... Erie
Homer ..... Cortland
Honeoye Falls .....Monroe
Hoosick Falls .....Rensselaer
Hornellsville ..... Steuben
Hudson ..... Columbia
Huntington ..... Suffolk
Italy Hollow.....Yates
Ithaca ..... Tompkins
Jamaica ..... Queens
Jamestown ..... Chautauqua
Jay ..... Essex
Johnsonville ..... Rensselaer
Johnstown ..... Fulton
Jordan ..... Onondaga
Keeseville ..... Essex
Kinderhook ..... Columbia
Kingston ..... Ulster
Lafayette ..... Onondaga
Lansingburgh ..... Rensselaer
Lebanon Springs.....Columbia
Le Roy..... Genesee
Liberty ..... Sullivan
Lily Dale.....Chautauqua

Lima ..... Livingston
Little Falls.....Herkimer
Little Valley.....Cattaraugus
Liverpool ..... Onondaga
Livonia ..... Livingston
Livonia Station.....Livingston
Lockport ..... Niagara
Logan ..... Schuyler
Long Island City.....Queens
Lowville ..... Lewis
Ludlowville ..... Tompkins
Lysander ..... Onondaga
Lyons ..... Wayne
Madison ..... Madison
Malone ..... Franklin
Mamaroneck ..... Westchester
Mannsville ..... Jefferson
Margaretville ..... Delaware
Marion ..... Wayne
Massena ..... St. Lawrence
Matteawan ..... Dutchess
Mechanicsville ..... Saratoga
Mecklenburgh ..... Schuyler
Medina ..... Orleans
Medway ..... Greene
Memphis ..... Onondaga
Mexico ..... Oswego
Middleport ..... Niagara
Middletown ..... Orange
Milbrook ..... Dutchess
Millport ..... Chemung
Modena ..... Ulster
Mohawk ..... Herkimer
Moriah ..... Essex
Moravia ..... Cayuga
Morris ..... Otsego
Morrisville ..... Madison
Mount Kisco..... Westchester
Mount Vernon..... Westchester
Naples ..... Ontario
Nelsonville ..... Westchester
Newark ..... Wayne
Newark Valley..... Tioga
New Berlin..... Chenango
New Brighton..... Richmond
Newburgh ..... Orange
New Paltz..... Ulster
New Rochelle.....Westchester
New Scotland..... Albany
New York.....New York
Niagara Falls..... Niagara
Niverville ..... Columbia
North Granville.....Washington
North Tonawanda..... Niagara
North Tarrytown....Westchester
Norwich ..... Chenango
Norwood ..... St. Lawrence
Nunda ..... Livingston
Nyack ..... Rockland
Oak's Corners..... Ontario
Ogdensburg.....St. Lawrence
Olean ..... Cattaraugus
Oneida ..... Madison
Oneonta ..... Otsego
Ontario ..... Wayne
Oswego ..... Oswego
Otsego ..... Otsego
Ovid ..... Seneca
Owasco ..... Cayuga
Owego ..... Tioga
Oxford ..... Chenango
Palermo ..... Oswego
Palmyra ..... Wayne
Panama ..... Chautauqua
Patchogue ..... Suffolk
Patterson ..... Putnam
Pavilion ..... Genesee
Peekskill ..... Westchester
Penfield ..... Monroe
Penn Yan ..... Yates
Perry ..... Wyoming
Phelps ..... Ontario
Phœnix ..... Oswego
Pike ..... Wyoming
Pittsford ..... Monroe
Plattsburg ..... Clinton
Pleasantville ..... Westchester
Port Chester ..... Westchester
Port Crane..... Broome
Port Gibson ..... Ontario
Port Jervis..... Orange
Potsdam .....St. Lawrence
Poughkeepsie ..... Dutchess
Randolph ..... Cattaraugus
Redwood ..... Jefferson
Rhinebeck ..... Dutchess
Richfield Springs..... Otsego
Riverhead ..... Suffolk
Rochester .....Monroe
Rome ..... Oneida

Round Lake..... Saratoga
Royalton ..... Niagara
Salamanca ..... Cattaraugus
Salem ..... Washington
Salt Point ..... Dutchess
Sandy Hill..... Washington
Saranac Lake..... Franklin
Saratoga Springs .....Saratoga
Saugerties .....Ulster
Savannah ..... Wayne
Schenectady ..... Schenectady
Scott ..... Cortland
Seely Creek..... Chemung
Seneca Falls ..... Seneca
Sherburne ..... Chenango
Shortsville ..... Ontario
Shrub Oak ..... Westchester
Silver Creek ..... Chautauqua
Sinclairville ..... Chautauqua
Sing Sing ..... Westchester
Skaneateles ..... Onondaga
Slate Hill..... Orange
Smithville Flats..... Chenango
Sodus ..... Wayne
South Butler ..... Wayne
South Byron..... Genesee
South Greece..... Monroe
Southold ..... Suffolk
Springville ..... Erie
Springwater ..... Livingston
Staatsburgh ..... Dutchess
Syracuse ..... Onondaga
Theresa ..... Jefferson
Ticonderoga ..... Essex
Tonawanda ..... Erie
Tottenville ..... Richmond
Trenton ..... Oneida
Troy ..... Rensselaer
Trumansburgh ..... Tompkins
Tully ..... Onondaga
Unadilla ..... Otsego
Union ..... Broome
Utica ..... Oneida
Victor ..... Ontario
Walden ..... Orange
Walton ..... Delaware
Walworth ..... Wayne
Wappinger's Falls.....Dutchess
Warner's ..... Onondaga
Warsaw ..... Wyoming
Warwick ..... Orange
Washingtonville ..... Orange
Waterford ..... Saratoga
Waterloo ..... Seneca
Watertown ..... Jefferson
Waterville ..... Oneida
Watervliet ..... Albany
Watkins ..... Schuyler
Waverly ..... Tioga
Wayland ..... Steuben
Webster ..... Monroe
Weedsport ..... Cayuga
Wellsville .....Allegany
Westbury Station..... Queens
Westfield ..... Chautauqua
West Eaton ..... Madison
West Henrietta ..... Monroe
West New Brighton..Richmond
Westport ..... Essex
Whitehall ..... Washington
White Plains..... Westchester
Whitesboro ..... Oneida
Williamsbridge .... Westchester
Williamson ..... Wayne
Williamstown ..... Oswego
Wilson ..... Niagara
Wolcott ..... Wayne
Wyoming ..... Wyoming
Yonkers ..... Westchester
Yorkshire ..... Cattaraugus

OPENINGS FOR PRACTICE.

County.	Location.	Reference.
ALLEGANY,	**Alfred,**	Dr. J. P. HUNTING, Alfred
CHAUTAUQUA,	**Brocton,**	DR. RIEGER, Dunkirk
"	**Mayville,**	DR. RICE, Jamestown
COLUMBIA,	**Chatham,**	DR. H. C. VAN BUREN, 163 Halsey
"	**Philmont,**	New York, Brooklyn.
DUTCHESS,	**New Hackensack,**	DR. A. C. HOWLAND, Poughkeepsie
ERIE,	**Hamburg,**	DR. W. D. YOUNG, 29 Park, Buffalo

FRANKLIN,	**Malone,**	DR. D. K. BELDIN, Malone
GREENE,	**Athens,**	DR. H. C. VAN BUREN, Brooklyn
LEWIS,	**Lowville.**	DR. M. H. BRONSON, Lowville
LIVINGSTON,	**Avon,**	DR. SKINNER, Le Roy
MONROE,	**Scottsville,**	DR. WALKER, West Henrietta
ONEIDA,	**Clinton,**	DR. I. DEVER, Clinton
ONONDAGA,	**Manlius,**	DR. L. B. RICHARDS, Oswego
OSWEGO,	**Pulaski,**	" "
ORANGE,	**Cornwall-on-Hudson,**	MRS. R. S. BERGEN, "The Cedars"
STEUBEN,	**Addison,**	DR. W. D. YOUNG, 29 Park St., Buffalo
SUFFOLK,	**Bay Shore,**	DR. RAYMOND, Islip
	Westfield, N. J.,	W. G. PECKHAM, ESQ., Westfield, N. J.
	Atlanta, Ga.,	DR. SUSAN M. HICKS, Grand Building

ALBANY COUNTY.

Annual Meeting, Albany, second Tuesday in January, President, E. G. Cox; Vice-President, G. E. Noble; Secretary and Treasurer, A. B. Van Loon.

ALBANY.

††Blessing, Elmer A., 93 Hudson Avenue.
*‡Carroll, Stephen H., 228 State.
††Cochran, H. D., Hom. Hosp.
*‡Cox, Edward G., 261 State.
*‡Cox, Frederick J., 109 State.
*‡Cox, Geo. A., 80 S. Swan.
Dowling, J. Ivimey, 214 State.
*‡Gorham, G. E., 160 Hamilton.
*‡Hunting, Nelson, 155 Hamilton.
*‡McKown, Wm. J., 335 Hamilton.
*‡Milbank, W. E., 111 State.
*‡Nead, W. M., 205 State.
*‡Van Loon, Arthur B., 50 Eagle.
Waite, S F., Hom. Hospital.

COHOES.

Mott, Albert, 105 Mohawk.
‡Campbell, Wm. M

NEW SCOTAND.

‡Fitch, J. H.

WATERVLIET.

Van Denbergh, Fred P., 220 23d.

ALLEGANY COUNTY.

No Society.

BELFAST

*Chamberlain, J. H.
Todd, W. S.

BELMONT.

Hardie, Wm. J.
Paul, W. K.

FRIENDSHIP.

*Williamson, Bemsley.

WELLSVILLE.

Gish, C. L.

BROOME COUNTY.

Annual Meeting, Binghamton, third Wednesday in June. President, E. E. Snyder; Vice-Presidents, — Merrill, J. F. Roe; Secretary and Treasurer, W. F. Ward.

BINGHAMTON.

‡Bates, J. B., 29 Arthur.
†‡Bailey, D. P., 41 Court.
*‡Corwin, Elizabeth, 104 Main.
Dildine, Ida L., 116 Main.
‡Hand, Geo. F., 79 Court.
*‡Jenkins, Geo. H., 139 Main.
*‡Martin, Lynn A., 74 Exchange.
*‡McGraw, De Witt H., 3 and 4 Hagaman Building.
‡Mills, Mrs. Alice F., 19 Main.
*‡Proctor, Willis H., 25 Main.
*‡Roe, J. F., 25 Main.
*‡Snyder, E. E., 27 Main.
‡Stoutenburg, A. W., 27 Main.
*Turner, T. S., 231 Chenango.
*‡Ward, Charles A., 33 Court.
‡Ward, W. F., 33 Court.
‡Winters, C. S., 122 Court.

CONKLIN CENTER.

†‡Mandeville, F. de L.

DEPOSIT.

Graffin, J. C.
Leonard, H. K.

PORT CRANE.

Tiffany, J. T.

UNION.

Knapp, Theodore P.

CATTARAUGUS COUNTY.

No Society.

LITTLE VALLEY.

Barnes, F. G.

OLEAN.

*Hibbard, DeVere M., 112 Berry.
Jepson, Mary B.
Watts, T. E.

GOWANDA.

*Zwetsch, J. D., 23 Main.

RANDOLPH.

Whipple, ——.
Babcock, A. H.

SALAMANCA.

Martin, O. S.

YORKSHIRE.

Sovereign, Baxter.

CAYUGA COUNTY.

No Society.

AUBURN.

*Babbitt, Otis H., 178 Genesee.
Baker, A. E., 55 Franklin.
Boyce, C. W., 19 South.
Bresley, Chas. H., 1 Cayuga.
*Frye, M. M., 167 Genesee.
*Gwynn, Charles A., 13 Grover.
Gwynn, W. M., 14 Grover.
Heartwell, W. B., 78 Genesee.
Hyatt, F. M., 49 E. Genesee.
Robinson, Robt. W., 30 Court.
Smith, Truman K., 173 Genesee.
Swift, Chas. L., 159 Van Anden.

MORAVIA.

Cook, Wm. C.

OWASCO.

Ford, N. B.

WEEDSPORT.

*‡Barnes, C. F.

CHAUTAUQUA COUNTY.

No Society.

DUNKIRK.

*Rieger, Jos., 404 Central Ave.
Vosburg, W., 327 Lion.

FREDONIA.

*Couch, Asa S.
Dods, A. Wilson.
Evans, A. J.

JAMESTOWN.

Morgan, Laura.
Neville, Henry.
Ormes, F. D., 320 Main.
Rice, Alvin B., Main and Third.
Scott, John W.
Ward, Alva F.

LILLY DALE.

Hyde, E. C.

MAYVILLE.

Robbins, A. J.

PANAMA.

Young, A. D.

SILVER CREEK.

Cole, ——.

WESTFIELD.

*Seymour, G. W.

CHEMUNG COUNTY.

No Society.

BIG FLATS.

Davis, D. L.

CATLIN.

Thorn, Sarah Eddy.

ELMIRA.

*Adriance, F. W., 306 Lake.
*Eddy, Ermina C., 500 William.
*Gregory, G. W., 370 W. Church.
*Howland, Reeve B., 306 Lake.
Jenks, R. B.
*Noble, E. H., 410 E. Church.
Parkhurst, G. H.

MILLPORT.

*McPherson, P. J.

SEELY CREEK.

Robbins, A. F.

CHENANGO COUNTY.

Annual Meeting, third Tuesday in January; Semi-Annual, third Tuesday in June. President, R. E. Miller; Secretary and Treasurer, F. E. Roper.

GREENE.

Guy, C. N.

NEW BERLIN.

‡Tuttle, Ella M.

NORWICH.

‡Roper, F. E.

*‡Miller, R. E.

OXFORD.

†‡Ganow, G. J.

SHERBURNE.

‡Little, Wm.

CLINTON COUNTY.

PLATTSBURGH.

*Low, Elliot C., Oak, corner Brinkerhoff.

COLUMBIA COUNTY.

No Society.

CHATHAM.

Clark, Mary.

GHENT.

Green, J. H.

*Mull, P. W.

HUDSON.

*Cook, C. P.

Tracy, A. M.

KINDERHOOK.

Green, James.

LEBANON SPRINGS.

*Van Buren, B. L.

NIVERVILLE.

Mesick, John C.

CORTLAND COUNTY.

No Society.

CORTLAND.

Johnson, H. P.
Nash, E. B.
Santee, E. M.
Spalding, Julia H.

HOMER.

Potter, Leman W.
*Pratt, L. M.
Goodell, R. A.

SCOTT.

*Ball, Halsey J.

DELAWARE COUNTY.

No Society.

DEHLI.

*Schumann, Carl.

FRANKLIN.

Foote, J. H.

MARGARETVILLE.

Telford, John W.

WALTON.

Mowbray, J. L.
St. John, A. H.

DUTCHESS COUNTY.

Annual Meeting, Poughkeepsie, first Tuesday in October. Prest. H. Reed Hawley; Vice-Prest., J. H. Otis; Sec. and Treas., Anna C. Howland.

FISHKILL-ON-HUDSON.

Strong, J. R.

MATTEAWAN.

Dawson, J. G.

MILLBROOK.

‡Jacobus, S. J.

POUGHKEEPSIE.

*‡Case, Walter R., 239 Mill.
*‡Faust, Fred A., 16 Garden.
‡Howland, Anna C., 18 S. Hamilton.
*‡Lane, Chas. E., 280 Mill.
*‡Otis, John C.
†‡Otis, John H.
Peckham, A. L.

RHINEBECK.

Asher, Rutson E.
‡Godell, J. L.

SALT POINT.

†‡Angel, Milton H.

STAATSBURGH.

*‡Hawley, H. Reed.

WAPPINGER'S FALLS.

‡Baxter, William.

ERIE COUNTY.

No Society.

AKRON.

Parker, Frank D.

BUFFALO.

Babcock, C. W., 151 Allen.
Bæthig, H., 530 Pennsylvania.
*Beals, Herbert, 176 Franklin.
Blighton, W. V-R., 1067 Grant.
Bodenbender, Edward G., 660 Walden Ave.
Bodenbender, N.W., 804 Jefferson
Broardt, Peter, 394 Adams.
Bull, Alex. T., 184 Franklin.
Carter, P. L., 35 Lafayette Ave.
*Chadwick, J. G., 262 Delaware Ave.,
*Cook, J. T., 636 Delaware Ave.
Crandall, W. A., 155 S. Division.
Critchlow, Geo. R., 505 Norwood Ave.
Dean, D. A., 89 Riley.
*Decker, W. M., 97 W. Genesee.
*Erb, Peter, 32, 34 Palace Arcade
Fisher, E. A., 1038 Fillmore Ave.
*Foster, Hubbard A., 3 St. John's Place.
Frost, H. C., 212 Delaware Ave.
Hadley, W. A. M., 63 W. Huron.

Halbert, J. S., 459 Franklin.
*Heineman, John D., 77 E. Eagle.
Hussey, E. P., 493 Porter Ave.
*Kenyon, W. B., 13 E. Swan.
*Lewis, Fred. D., 188 Franklin.
*Lewis, F. Park, 454 Franklin.
Lewis, G. W., Jr., 311 Delaware Avenue.
Linquist, M. F., 175 Bryant.
Long, W. E., 364 W. Delavan Av.
*McCrea, Philip A., 134 Morris Avenue.
McGill, W. D., 296 S. Division.
Marcy, W. H., 1148 Main.
*Martin, Truman J., 140 North.
*Maycock, B. J., 33 Allen.
*Miller, John, 48 St. John's Place
*Moseley, G. T., 202 Delaware Avenue.
Parmenter, W. L., 931 Prospect Avenue.
Reed, Mark E., 24 Como Ave.
Root, Reuben M., 40 Krettner.
Salter, A. E., 939 Ellicott.
Seaman, C. W., 215 Hoyt.
*Seitz, F. B., 33 N. Pearl.
*Shepard, Jessie, 21 Irving Pl.
*Stearns, G. R., 201 Linwood Avenue.
*Stumpf, Daniel B., 631 Ellicott.
Wage, John F., 414 Seneca.
*Wilcox, DeWitt G., 173 Lexington Ave.
Wilder, Rose C., 388 West Ferry.
*Wright, A. R., 414 Elmwood Avenue.
Young, Wm. D., 29 Park.

GOWANDA STATE HOMOEOPATHIC HOSPITAL.

*Adams, G. F.
*Arthur, D. H.
*Potter, Clarence A.

EAST AURORA.

Mitchell, A. L.

HOLLAND.

Noble, W. A.

SPRINGVILLE.

Caulkins, Frank.

TONAWANDA.

Simpson, John R.

ESSEX COUNTY.

No Society.

CROWN POINT.

Eaton, Erwin R.

ELIZABETHTOWN.

Wasson, T. A.

ESSEX.

Chase, Edwin R.

JAY.

Toby, C. McV.

KEESEVILLE.

Pope, Willis G.
Severance, Karl.

MORIAH.

Powell, George W.

TICONDEROGA.

Bond, George W.

WESTPORT.

*Shattuck, J. W. M.

FRANKLIN COUNTY.

MALONE.

Belding, D. K.

SARANAC LAKE.

*Hallock, J. Henry.

FULTON COUNTY.

(‡*Montgomery County Society.*)

GLOVERSVILLE.

Bissell, D. A.
*‡Eisenbrey, E. H.
*‡Garnsey, W. S., 77 N. Main.
*‡Hill, Emily L.
‡Knott, Harriet A.
Tuck, Arthur E.

JOHNSTOWN.

*‡Walrad, C. B.

GENESEE COUNTY.

No Society.

ELBA.

Lewis, J. M.

BATAVIA.

Baker, John W., 5 Bank.
*Cole, Directus DeForest.
*Hutchins, H. S., 215 E. Main.
*LeSeur, J. W., 207 E. Main.

CORFU.

Carrier, Eugene W.

LE ROY.

*Skinner, Scott W., 12 Myrtle.
Skinner, S. W., Jr.

PAVILION.

Sweeting, S. C.

SOUTH BYRON.

Whiton, Alpha M.

GREENE COUNTY.

No Society.

CATSKILL.

*Vincent, Stanley, 262 Main.

COXSACKIE.

Klaer, Clarence.

MEDWAY.

Collins, D. E.

HAMILTON COUNTY.

(No Homœopathist.)

HERKIMER COUNTY.

(‡*Oneida County Society.*)

HERKIMER.

‡Kern, E. G.

LITTLE FALLS.

*‡Brainard, L. L.

MOHAWK.

Landt, Wm.

JEFFERSON COUNTY.

Annual Meeting, Watertown, third Wednesday in November. Prest. J. E. Ryan; Vice-Prest., G. A. Gifford; Sec. and Treas., R. F. Gates.

ADAMS.

*‡Nickelson, W. H.

ALEXANDRIA BAY.

Campbell, E. E.
Cole, J. D.

ANTWERP.

Flint, ——.

BROWNVILLE.

‡Gates, R. F.

CAPE VINCENT.

Bushnell, H. N.

CARTHAGE.

‡Simonds, C. A.
‡Simonds, E. A.

MANNSVILLE.

‡Hibbard, G. C.

REDWOOD.

‡Ryan, J. E.

THERESA.

*‡Santway, F. L.
Dresser, E. Dell.

WATERTOWN.

‡Bartlett, Geo. W.
Chattaway, A. D.
‡Farmer, G. S.
‡Gifford, G. A.
Smith, G. W. B.
Flint, ——.

KINGS COUNTY.

Annual Meeting, 44 Court St., Brooklyn, second Tuesday in January. Prest. Orando S. Ritch; Vice-Prest., W. H. Aten; Sec., E. Rodney Fiske; Treas., C. W. Smith; Necrologist, B. W. Bierbauer.

NEW YORK, BROOKLYN BOROUGH.

*‡Allen, Emma T. P., 310 Clermont Avenue.
*‡Allen, Herbert C., 310 Clermont Avenue.
†‡Aten, Wm. H., 100 Greene Ave
*‡Avery, E. W., 16 Hancock.
†‡Ayres, Rebecca J., 509 Van Buren.
*‡Baker, Jennie v. H., 512 Bedford Avenue.
*‡Barkeloo, Harriet, 915 Third Avenue.
Barnes, Roxana K., 161 Garfield Place.
Barnum, Fr'd'k L., 798 Bedford Avenue.
*‡Baylies, B. L'B., 418 Putnam Avenue.
†‡Bedford, E. R., 814 Marcy Ave. Avenue.
*‡Bennet, G. H. R., 21 S. Portland Avenue.
*‡Bierbauer, B. W., 85 Pierrepont
‡Birdsall, A. T., 344 Washington Avenue.
‡Bishop, Gertrude G., 475 Madison.
Black, J. Torrington, Brooklyn Hom. Hospital.
Blackman, Mrs. Lora, 519 Clinton Avenue.

*‡Blackman, W. W., 519 Clinton Avenue.
*‡Bolan, L. W., 413a Quincy.
Bond, Frank, 27 Schermerhorn.
*‡Bonnell, Chas. L., 3 Hanson Place.
*Boocock, Robert, 965 Flatbush Avenue.
‡Breck, William B., 235 Garfield Place.
‡Brinkerhoff, A. S., 546 Monroe.
‡Bronson, Chas. H., 438 Pacific.
†‡Broughton, L. D., Jr., 418 Madison.
Brown, Annie M., 155 Halsey.
*‡Brown, Charles A., 155 Halsey.
*‡Bryant, W. C., 64 Greene Ave.
*Bulmer, George W., 1210 Bushwick Avenue.
‡Burnette, Katherine D., 486 Bedford Avenue.
*‡Burnham, Clark, 182 Clinton.
*‡Butler, W. M., 507 Clinton Avenue.
†‡Buys, Thos. L., 1483 Bedford Avenue.
*‡Caldwell, Frank E., 151 Henry.
†‡Cameron, Elizabeth W. M., 23 Seventh Avenue.
Campbell, Alice B., 552 McDonough.
Campbell, John B., 638a Halsey.
‡Cardozó, Jacob L., 223a Monroe
‡Carman, Margaret A., 57 Tompkins Avenue.
Carr, H. L., 856 Lafayette Ave.
Casselberry, J. L., E. N. Y. Hom. Hospital.
*‡Cassidy, Georgia A., 703 Nostrand Avenue.
*Chamberlin, W. T., Bkn. Hom. Hospital.
*‡Chapin, Edward, 21 Schermerhorn.
‡Chaplain, F. T., 324 Sumner Avenue.
‡Clark, G. F., 515 Decatur.
†‡Clarke, M. Elizabeth, 8 Lafayette Avenue.
‡Close, Stuart, 641 Willoughby Avenue.
‡Coddington, Fannie R., 16 Ormond Place.
‡Cornell, George B., 137 Seventh Avenue.
†‡Cort, Lottie A., 89 Division Avenue.
*‡Denison, R. N., 55 Eighth Ave.
Dewey, Geo. A., 519 Halsey.
†‡Devol, Edmond, 114 Milton.
Deyo, J. T., 364 Ninth.
‡Diehl, W., Jr., 150 Cornelia.
*‡Doty, George H., 245½ Cumberland.
Dunlevy, Mrs., 166 DeKalb Ave.
Durkee, Jeannette R., 197 Harrison.
Eaton, J. Albro, 498 Hancock.
*‡Elliot, Amos H., 480 Monroe.
Ermentraut, Henry, 324 S. 5th.
Ermentraut, J. P., 134 Hendrix.
†‡Fawdray, J. W., 242 Clermont Avenue.
‡Fincke, Bernhard, 122 Livingston.
*‡Fiske, E. R., 488 Nostrand Ave
*‡Fiske, W. M. L., 484 Bedford Avenue.
‡Freckles, Mary Fish, 530 Lafayette Avenue.
‡Gerrie, James, 357 Halsey.
‡Given, James B., 359 Eleventh.
*‡Gorton, D. A., 137 Clinton.
*‡Hadley, C. H., 58th and 13th Avenue, Blythebourne.
‡Hale, Harriet W., 387 Monroe.
Hamilton, C. T., 103 Park Pl.
Hanford, S. C., 178 S. Fifth.
*‡Hasbrouck, Everitt, 369 Ninth.
‡Heywood, Abner, 426 Franklin Avenue.
‡Hobby, Ada T., 944 Marcy Ave.
Hopke, F. Edward, W., Brooklyn Hom. Hospital.
‡Hopper, M. T., 63 S. Oxford.
‡Houghton, B. L., 616 St. Marks Avenue.
‡Hudson, W. T., 218 Livingston.
Hunt, Ida B., 363 Gates Ave.
†‡Iler, G. H., 237 McDonough.
Jarrett, A. R., 91 Halsey.
*‡Jeffery, G. C., 343 Jefferson Av.
*‡Jenks, F. Percy, 419 Ninth.

*‡Johnston, C. L., 467 Vanderbilt Avenue.
*‡Kastendieck, J. T. W., 149 Keap.
Keep, J. Lester, 460 Clinton Ave.
‡Knapp, H. J., 287 South 5th.
Lanzer, Lewis, 404 S. 3d.
‡Lassen, Helene S., 152 Henry.
‡Latimer, W. C., 351a Clinton.
*‡Lauer, Chas. F., 248 Emerson Place.
*‡Lawrence, J. B., 289 Ninth.
†‡Lazarus, Geo. F., 6 Caton Ave.
Leverson, M. R., 96th, near Shore Road.
‡Lines, Mary L., 344 Washington Avenue.
Lines, O. T., 344 Washington Av.
‡Lloyd, R. I., 296 Forty-seventh.
†‡Love, Wm. L., 1188 Dean.
Lowe, Evelyn, 944 Marcy Ave.
*‡Lutze, F. H., 212 Keap.
‡Martin, Ella M., 461 Halsey.
Martin, Kenneth B., 123 Prospect
‡Martineau, S. Catherine, 309 Clinton.
Martino, R. R., 74 Wyona.
McCune, Olive F., 53 Orange.
†‡McLenathan, W. H., 101 Division Avenue.
Mead, Byron E., 443 Pacific.
Metcalf, J. W., 71 Stone Ave.
‡Minshull, Frances E., 130 Halsey
*‡Minton, Henry B., 165 Joralemon.
*‡Moffat, John L., 17 Schermerhorn.
‡Monmonier, J. L., 480 Classon Avenue.
†‡Moon, W. W., 184 Macon.
*‡Muncie, E. H., 119 Macon.
*‡Muncie, Mrs. L. H., 119 Macon
Newcomb, Geo. W., 191 Adelphi.
‡Nichols, George, 306 Monroe.
‡Nottage, Rachel, 669 Macon.
Oakey, Fannie M., 865 Union.
*‡Ogden, G. S., 24 Kenilworth Pl
‡Onderdonk, Emma, 104 South Elliott Place.
‡Pallister, Stanley W., 376 Madison.
‡Palmer, A. J., 90 Hancock.
†‡Palmer, G. H., 92 Hancock.
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Bettis, J. T.

LIVONIA STATION.

Trimmer, W. S.

MOUNT MORRIS.

*Leach, A. E.

NUNDA.

*Ostrander, P M.

SPRINGWATER.

Whitfield, H. A.

MADISON COUNTY.

Annual Meeting, Oneida, fourth Tuesday in June. Prest. B. R. Gifford; Vice Prest., E. N. Coon; Sec. and Treas., J. T. Wallace.

CAZENOVIA.

‡Bass, E. C.

CHITTENANGO.

*‡Deuel, W. E.

DE RUYTER.

‡Coon, E. N.

EARLVILLE.

Hakes, ——.

EAST HAMILTON.

‡Palmer, G. B.

HAMILTON.

*‡Gifford, G. L.

‡Bardwell, —.

‡Willcox, G. W.

MADISON.

‡Gifford, Barton R.

MORRISVILLE.

Bresee, Charles H.

ONEIDA.

‡Wallace, J. T.

Davis, Lavinia R.

WEST EATON.

Burnham, Fred.

MONROE COUNTY.

Annual Meeting, Rochester Homœopathic Hospital, third Tuesday in January. Prest., H. W. Hoyt; Vice-Prest., L. L. Button, Sec., L. J. Sanders; Treas., H. A. Anderson.

BRIGHTON.

Wheeler, J. P.

BROCKPORT.

Winne, F. A.

EAST HAMLIN.

Darrow, S. W.

FAIRPORT.

*‡Clapp, W. F.

††‡Tubbs, J. F.

‡Price, George S.

HONEOYE FALLS.

Brown, D. G.

*‡Otis, Chas. F.

PENFIELD.

Humphrey, N. M.

PITTSFORD.

*‡Doane, W. H.
Johnson, W. W.

ROCHESTER.

*‡Adams, Myron H., 821 Granite Building.
*‡Adams, R. A., 46 N. Fitzhugh.
‡Anderson, H. A., 391 West Ave.
*‡Bachman, G. A., 167 South Avenue.
Biegler, J. A., 58 Clinton Avenue South.
*‡Bissell, E. J., 75 S. Fitzhugh.
Brownell, J. R., Hom. Hospital.
Brownell, W. G., 122 North.
*‡Buell, Jesse W., 41 Clinton Avenue, South.
Bunnell, L. M., Jr., Hahnemann Hospital.
‡Button, L. L., 44 Clinton Ave., South.
†‡Carman, W. B., 23 Upton Park.
Carr, Allen B., 89 Clinton Ave., North.
†‡Chamberlayne, Mrs. Louise F., 28 Emerson.
‡Clapp, C. R., 47 Hayward Ave.
*‡Collins, N. M., 43 East Avenue.
Cox, J. T., 333 Clinton Avenue, North.
Dake, W. E., 92 Pearl.
Earle, E. W., 55 Monroe Ave.
*‡Fowler, W. P., 63 Clinton Ave., South.
Fritz, A. R., 28 Draper.
*‡Graham, M. E., 10 Jones Avenue.
Grant, R. C., 279 South Avenue.
*‡Haywood, G. M., 48 Clinton Avenue South.
*‡Haywood, Julia F., 612 West Avenue.
Hermance, A. C., 611 St. Paul.
Hermance, S. G., 95 Henrietta Av.
Hoard, V. A., 637 Main, East.
*‡Hoyt, Herbert W., 75 S. Fitzhugh.
*‡Hoyt, Mrs. Mary M., 10 Westminster Road.
*‡Keegan, W. A., 40 Clinton Avenue, South.
*‡Kellogg, C. M., 42 Clinton Avenue, North.
*‡Lee, J. M., 121 Lake Ave.
*MacCallum, John H., 408 Monroe Avenue.
Morton, Pauline, 411 Beckley Building.
*‡Neefus, P. W., 124 East Ave.
Norman, A. J., 11 Peart Pl.
*‡Parsons, Thomas, 33 Clinton Avenue, South.
Perrine, C. W., 76 Clifton.
*Phillips, R. F., 21 Park Ave.
Proctor, J. C., 29 Buckingham.
*‡Rambo, W. S., 41 Sophia.
*‡Ricker, Mrs. M. S., 58 Lorimer.
Ross, E. V., 279 Jefferson Ave.
*‡Sanders, L. J., 421 Monroe Ave.
Sayles, Emma S., 13 Park Ave.
Seeley, J. E., 138 Main, East.
‡Shepard, H. G., 43 East Ave.
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*‡Snow, S. R., 267 Alexander.
*‡Spencer, T. D., 24 S. Union.
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*‡Sumner, C. R., 33 Clinton Avenue, South.
Thomson, G. M., 246 East Ave.
Thorpe, J. L., Hom. Hospital.
*‡Thurber, T. J., 157 Plymouth Avenue.
†‡Tretton, J. K., 239 Lake Ave.
‡Van Allan, R. A., 234 Monroe Avenue.
White, B. R., Hom. Hospital.
Winans, W. W., Hom. Hospital.
*‡Wolcott, E. H., 57 Union, S.

SCOTTSVILLE.

Archer, D. E.

SOUTH GREECE.

*‡Buell, E. S., (Lic.)

WEBSTER.

‡Whittleton, E. J.

WEST HENRIETTA.

*‡Walker, C. E.

MONTGOMERY COUNTY.

Annual Meeting at Fonda, second Tuesday, Quarterly Meetings. Prest., Wm. M. White; Vice-Prest., Louis Faust.

AMSTERDAM.

*‡Frazier, L. A., 124 Division. ‡Hicks, H. M.
‡White, Wm. M., 26 Pearl.

FONDA.

Foster, —.

FORT PLAIN.

‡Zoller, Wm.

NASSAU COUNTY.

No Society.

GLEN COVE.

*Foster, W. E.

HEMPSTEAD.

Lount, Robert, 79 Fulton.

NEW YORK COUNTY, (MANHATTAN AND BRONX BOROUGHS.)

Annual Meeting, second Thursday in December, at Carnegie Hall. President, F. H. Boynton; Vice-Prest., Irving Townsend; Sec., J. Perry Seward; Treas., C. S. Macy; Librarian, Chas. Ver Nooy.

*‡Allan, Arthur G., 8 W. 49th.
†‡Allen, J. Wilford, 110 W. 12th.
*‡Allen, Paul, 3 E. 48th.
*‡Allen, T. F., 3 E. 48th.
*‡Ambler, J. Edgar, Broadway and 52d.
†‡Andrew, R. M., 1777 Bathgate Ave.
Arcularius, P. E., 104 W. 44th.
†‡Arschagouni, John, 743 Lexington Ave.
Atkins, L. R., 304 W. 30th.
Austin, A. E., 17 E. 66th.
†‡Bagg, C. L., 67 W. 45th.
Baker, C. M., 43 Sixth Avenue.
‡Baker, C. R., 144 Convent Ave.
Baker,, Daniel J.
*‡Baldwin, J. G., 8 East 41st.
‡Bartlett, G. W., 27 E. 111th.
Baruch, E., 183 Lexington Ave.
Baruch, Solomon, 1047 Lexington Avenue.
Bassett, J. S., 11 West 31st.
‡Beals, M. B., 97 E. 116th.
*‡Beebe, C. E., 3 W. 37th.
‡Bennett, J. A., 4 Irving Place.

*‡Berghaus, A., 138 East 65th.
*‡Beyea, J. L., 217 Second Ave.
†‡Bickford, Lydia A., 45 W. 39th.
‡Bigelow, A. J., 163 E. 106th.
*‡Bishop, Wm. H., 46 W. 48th.
Bissell, Sarah E., 51 East 20th.
Black, Caroline L., 114 W. 123d.
Blakeman, J. L., 1977 Seventh Av
*‡Bond, Mary E., 122 Lexington Avenue.
Bonschur, G. A., 127 W. 22d.
*‡Boyle, C. C., 49 W. 37th.
*‡Boynton, F. H., 36 West 50th.
‡Bren, M. R., 1949 Seventh Ave.
‡Brown, G. C., 56 West 45th.
*‡Brown, M. Belle, 135 W. 34th.
†‡Buchanan, T. D., 328 W. 24th.
*‡Buchholz, Louise Z., 73 E. 8th.
Burd, Emma de L., 100 W. 88th.
*Burdick, Mrs. Alice H., 341 W. 34th.
Campbell, Annie S., Jerome Ave. and 165th.
‡Campbell, C. E., 314 East 18th.
‡Cannon, M. D., 167 W. 128th.
*‡Carleton, B. G., 75 W. 50th.
‡Carleton, E., 62 W. 49th.
Chamberlin, G. W.
‡Chapman, A. E., 234 West 43d.
*Charles, Emily C., 51 W. 127th.
*‡Chase, J. O., 214 East 53d.
*‡Church, Eloise I., 41 W. 94th.
*‡Clark, B. G., 162 West 122nd.
Clark, C. C.
Clock, Sarah A., 233 W. 51st.
Coles, H. L., 83 W. 104th.
*Cooke, Mrs. H. N. F., 41 W. 65th.
‡Cooley, Helen, 110 W. 84th.
*‡Cornell, C. W., W. 72d and Boulevard.
‡Cossart, A. B., 1378 Lexington Avenue.
Crompton, Chas. W., 1894 Boston Avenue.
*‡Crump, W. G., 693 Madison Av.
Dale, Marian A., 17 E. 124th.
*‡Danforth, L. L., 59 W. 52d.
Daniels, J. L., 51 West 127th.
Davis, Jane C., 138 E. 48th.
*‡Davis, J. E. L., 743 Madison Ave.
Davis, T. F., Flower Hospital.
*‡Deady, Chas., 110 West 48th.
*‡Dearborn, H. M., 146 W. 57th.
Decker, J. W., Flower Hospital.
*‡Delabarre, W. E., 224 W. 59th.
*‡Demarest, J. H., 1969 Madison Ave.
*‡Deschere, Martin, 334 W. 58th.
*‡Dillingham, T. M., 8 W. 49th.
*‡Dillow, George M., 57th and Broadway.
‡Donoghue, Anna F., 400 W. 57th
*‡Doughty, F. E., 512 Madison Avenue.
*‡Dowe, F. Le C., 332 Alexander Avenue.
Dowling, George B., 32 E. 30th.
*‡Dowling, J. W., 8 W. 45th.
*‡Dryer, F. H., Webster Ave., Fordham.
Dunham, Mrs. E., 19 W. 81st.
†‡Dunlevy, Rita, 328 W. 57th.
‡Durrie, G. B., 103 W. 54th.
Eden, J. H., St. James, near Aqueduct Avenue.
†‡Edwards, Mary L., 19 W. 46th.
*‡Eife, Arthur F., 175 W. 10th.
Eife, Francis, 335 E. 18th.
Elebash, Carl P., 118 E. 19th.
Elebash, Clarence S., 118 E. 19th.
Elmendorf, T. C., 344 E. 42d.
Ely, L. W., 114 W. 86th.
‡Emery, Mary E., 142 W. 48th.
‡Ermentraut, J. P., 33 7th St.
*‡Eurich, C., 349 E. 85th.
*‡Ferrier, Jas. M., 166 E. 111th.
Finch, Joseph, 106 W. 44th.
Fleming, Laura M., 57 W. 45th.
Fleming, W. L., 309 W. 121st.
Fletcher, Z. P., 1379 Lexington Avenue.
*‡Fralick, W. G., 778 Madison Avenue.
*‡Franklin, E. D., 325 W. 14th.
‡Gage, Mary E., 19 W. 46th.
Garrison, H. W., 154 E. 86th.
*‡Garrison, J. B., 111 E. 70th.
Gaydé, E. A., Hahnemann Hosp.

Gennerich, Chas., 154 E. 62d.
Gilbert, C. E., 343 W. 23d.
Gilbert, Mrs. M. H., 15 E. 11th.
‡Gillingham, H. P., 161 E. 77th.
*‡Goodrich, S. W., 507 W. 152d.
*Gore, Jennie E., 1145 Park Avenue.
Graffin, J. C., Hahnemann Hosp.
‡Graham, N. C., 261 W. 34th.
*‡Guernsey, Egbert, 180 W. 59th.
‡Guernsey, Wm. N., 27 W. 52d.
‡Hall, James W., 335 W. 56th.
Haller, G. C.
††Hallett, G. D., 107 W. 82d.
*‡Hamlin, F. W., 130 W. 48th.
Hardy, O. S., 251 W. 104th.
‡Harrington, Gove S., 487 W. 145th.
Harris, Sallie A., 2145 Seventh Avenue.
††Hart, A. H., 130 W. 44th.
*‡Hartley, W. G., 335 W. 34th.
Hasbrouck, Stephen, 68 Broad.
*‡Hathaway, H. S., 146 W. 92d.
*‡Helfrich, C. H., 542 5th Ave.
*‡Helmuth, Wm. Tod, 504 Fifth Ave.
*‡Helmuth, W. T., Jr., 465 Lexington Avenue.
††Hiller, J. L., 110 W. 82d.
‡Hinkley, Abbie G., 142 W. 111th
Hitchcock, Harlyn, 19 Broadway.
Hitchcock, Henry M., 309 Broadway.
‡Hollister, F. K., 521 Madison Avenue.
*‡Honan, W. F., Boulevard and W. 71st.
*‡Houghton, H. C., 7 W. 39th.
‡Howard, C. C., 57 W. 51st.
*‡Howe, J. M., 58 W. 47th.
*‡Hoyt, F., 39 W. 58th.
*Hrdlicka, Ales, 106 E. 71st.
Hughes, D. Jane, 243 W. 42d.
‡Hull, G. A., 123 W. 73d.
*‡Hunt, D. B., 159 Madison Ave.
*‡Hunt, Oren G., 134 E. 19th.
‡Hutchinson, John, 693 Madison Avenue.
Irwin, F. C., Hahnemann Hosp.
††Jardin, Roland du, 129 E. 76th.
††Jarrett, Elizabeth, 159 W. 48th.
Jennings, Ella A., 208 W. 43d.
Johnson, P. R., 169 W. 76th.
Jones, W. H., 202 W. 74th.
‡Keatinge, Mrs. H. C., 119 W. 48th.
††Keatinge, Harriette d'E., 119 W. 48th.
‡Keep, Mrs. C. J. Y., 308 W. 36th
*‡Kellogg, E. M., (retired), 115 E. 37th.
Kelly, Chas. W., 473 Park Ave.
‡Kidder, Hugh, 347 W. 46th.
*‡King, W. Harvey, 64 W. 51st.
*‡Klots, E. D., 156 W. 48th.
Kolb, Henry, 356 W. 42d.
‡Krause, W. H., 329 E. 14th.
*‡Laidlaw, A. H. 137 W. 41st.
*‡Laidlaw, G. F., 137 W. 41st.
*‡Land, J. F., 130 W. 126th.
Langworthy, Anne L., 1381 Boston Avenue.
*Lannin, Louise, 148 W. 85th.
*‡Leal, Malcolm, 107 W. 48th.
Lerrigo, P. H. T., Flower Hosp.
Lewis, Henry M., 4th Ave. and 18th.
Lewis, N. H., 224 E. 23d.
Linquist, M. F., 211 W. 21st.
‡Linsley, J. S., 65 W. 70th.
Lozier, A. W., 125th and 7th Avenue.
‡MacBride, N. L., 4 E. 43d.
‡Mac Ivor, Abbie H., 675 E. 138th.
Mac Ivor, James H., 675 E. 138th
*‡Macy, C. S., 117 W. 12th.
††Maeder, J. G., 304 East 120th.
Mann, Mrs. M. F., 359 Lexington Avenue.
Martine, Jennie W., 16 W. 61st.
‡McDonald, R. E., 2065 Madison Avenue.
*‡McDonald, W. O., 117 W. 44th
*‡McDowell, Chas., 116 W. 13th.
*‡McDowell, Geo. W., 136 W. 130th, and 542 Fifth Ave.
*‡McMichael, A. R., 969 Madison Avenue.

*‡McMichael, D. A., 67 W. 96th.
McMichael, J. E., 23 E. 126th.
Meeker, I. A.
*‡Meyer, Oscar N., 171 E. 78th.
Miller, C. H., 128 W. 96th.
Miller, C. W., 115 E. 83d.
Miller, Nancy M., 41 W. 26th.
‡Mills, Walter S., 152 W. 119th.
‡Miner, F. C., 1150 Forest Ave.
‡Mitchell, Chas. A., 1812 Lexington Ave.
Mitchell, L. S., 2010 5th Ave.
Morgan, G. E., 2024 Madison Avenue.
†‡Morgenthaler, Sophia, 131 W. 64th.
Montgomery, R. W., 48 W. 94th.
*‡Mossman, N. A., 28 E. 47th.
Mount, Margaret A. B., 574 Lexington Avenue.
‡Müller, C. W., 225 East 83d.
†‡Munson, E. S., 16 W. 45th.
*‡Musits, H. von, 47 E. 83d.
Myers, Chas. F., 261 W. 37th.
*‡Neilson, Howard S., 46 W. 48th
Nahm, Mettler, 710 Madison Ave.
‡Newcomb, Obadiah, 233 E. 12th.
*‡Norton, A. B., 16 W. 45th.
*‡Nott, F. J., 554 Madison Ave.
†‡Nutter, Mary E., 144 Lexington Avenue.
Nye, F. A., 2089 Lexington Ave.
†‡O'Brien, Evelina C. D., 226 E. 87th.
‡O'Connor, Mrs. H. M. C., 18 W. 43d.
*‡O'Connor, J. T., 29 W. 45th.
*‡Ogden, E. G., 551 W. End Ave.
Ohley, C. H. Metrop. Hospital.
*‡Ostrom, H. I., 42 W. 48th.
*‡Paige, H. W., 256 W. 57th.
*‡Palmer, A. W., 138 W. 81st.
†‡Palmer, John B., 201 E. 23d.
‡Palmer, Miles W., 235 E. 18th.
‡Pardee, E. B., 218 W. 34th.
Pardee, Walter, 218 W. 34th.
†‡Patchen, G. H., 11 E. 59th.
Pearsall, S. J., 128 W. 78th.
*‡Pearsall, W. S., 128 W. 78th.
*‡Pease, Chas. G., 101 W. 72d.
*‡Pettet, Isabella M., 308 E. 15th.
*‡Pierce, W. Ide, 64 W. 126th.
Piersons, A. M., 24 E. 127th.
*‡Porter, E. H., 181 W. 73d.
‡Powel, Milton, 163 W. 76th.
*‡Queen, L. A., 114 W. 85th.
*‡Rabe, F. E., 227 W. 42d.
Rabe, R. F., 209 W. 56th.
‡Rankin, E. G., 226 W. 59th.
‡Rannefeld, A. H., 85 Seventh
Reisig, Richard, 438 Central Park, W.
Rennie, W. H.
*‡Reynolds, W. U., 320 Manhattan Ave.
Ricardo, J. N., 160 W. 133d.
*‡Richardson, A. J., 39 E. 83d.
*‡Richardson, G. W., 138 E. 79th
Riordan, P. D., Flower Hospital.
*‡Ritchie, F. G., 131 W. 47th.
Roberts, Eugene P., 248 W. 53d.
*‡Roberts, G. W., Broadway and 52d.
Roder, Elizabeth B., 231 E. 82d.
*‡Rounds, W. E., 154 W. 47th.
Royle, Sinclair K., 110 W. 84th.
*‡Rudderow, T. D., 328 W. 24th.
*‡Russell, H. E., 30 E. 74th.
*‡Schley, J. Montfort, 32 W. 49th
†‡Schroeder, Marie Ohlmeyer, 925 Jefferson.
*‡Scott, W. H., 104 W. 44th.
‡Sewall, S. G., 1686 Madison Ave.
†‡Seward, J. Perry, 113 W. 85th.
Sharp, Clarence, 163 E. 116th.
†‡Sheldon, F. P., 223 W. 122d.
*‡Shelton, G. G., 521 Madison Avenue.
*‡Shepard, G. A., Broadway and 52d.
*‡Sherman, Irving P., 114 W. 44th.
†‡Sherman, L. B., 355 W. 14th.
‡Simmons, R. S., 129 E. 59th.
†‡Simonson, J. F., 46 W. 85th.
*‡Simpson, E. D., 320 W. 115th.
Sinsabaugh, J. A., 672 2d Ave.
Slay, J. Clark, 1218 Broadway.
Smith, Caroline M., 240 W. 52d.
Smith, G. B., 35 E. 28th.

*‡Smith, Henry M., 33 W. 24th.
Smith, Max M., 221 E. 81st.
Smith, Nelson, Jr., 151 W. 48th.
‡Smith, Roswell D., 990 E. 169th.
Smith, Sarah N., 74 W. 35th.
*‡Smith, St. Clair, 25 W. 50th.
*‡Smith, T. F., 264 Lenox Ave.
‡Smyth, S. H., 112 E. 10th.
*‡Stanton, L. M., 132 W. 58th.
Stebbins, W. W.
Steger, G., 73 E. 66th.
*‡Stevens, Anna C. R., 247 W. 42d.
*Stevens, D. D., 170 W. 54th.
†‡Stewart, G. T., Metrop. Hosp.
Stewart, W. B., 71 E. 87th.
*Stiles, Henry R., care of F. Humphrey & Son.
*‡Storer, J. H., 30 Edgecombe Avenue.
Tantum, P. L., 272 W. 11th.
‡Tappen, Ella C. Jones, 346 W. 123d.
*‡Teets, C. E., 37 W. 39th.
Thompson, A. F.
‡Thompson, J. H., 36 E. 30th.
*‡Thompson, Virgil, 56 W. 21st.
‡Thomson, J. W., 159 W. 48th.
Tinker, Chas. A., 124 W. 121st.
Tinker, H. H., 1257 Washington Avenue.
†‡Townsend, Charles W., 144 W. 46th.
*‡Townsend, Irving, 67 W. 46th.
†‡Townsend, Katherine G., 354 W. 123d.
Townsend, Richard, 780 Lexington Avenue.
*‡Tuttle, E. G., 61 W. 51st.
*‡Tytler, G. E., 113 W. 126th.
*van den Berg, Wm. H., 32 W. 49th.
*‡Vehslage, S. H., 117 W. 43d.
‡Ver Nooy, Chas., 148 W. 64th.
‡Vondergoltz, Eric, 324 E. 15th.
†‡Wait, Phebe J. B., 9th Avenue and 34th.
‡Walker, B. D., 166 E. 117th.
Walker, L. E., 155 Worth.
Wallin, A. C., 487 W. 147th.
Welch, F. G., 54 W. 55th.
‡West, Edwin, 155 W. 12th.
*‡Wetmore, J. McE., 41 E. 29th.
Wheeler, John H., 319 W. 54th.
*‡White, A. Lenora, 151 W. 46th.
‡White, W. H., 56 W. 48th.
‡White, W. Storm, 58 W. 48th.
†‡Whitehorne, F. N., 64 W. 126th
‡Whittemore, Margaret, 32 W. 24th.
Whitmyre, J. P., Flower Hosp.
Wilcox, Emma D., 20 W. 104th.
*‡Wilcox, Sidney F., 51 W. 52d.
‡Wilder, L. de V., 55 W. 33d.
Wildes, Thomas, 610 Lexington Avenue.
*‡Williams, T. C., 118 E. 19th.
‡Winterburn, G. W., 309 West 113th.
‡Wood, J. Robie, 111 W. 74th.
‡Woodward, A. M., 128 W. 13th.
†‡Worrall, M. Ruth., 239 W. 44th.
†‡Wright, Amelia, 5 W. 82d.
‡Young, Chas. H., 160 W. 48th.
‡Zeckhansen, Harry, 128 E. 2d.

NIAGARA COUNTY.

No Society.

GASPORT.

Knapp, F. L. (retired).

LOCKPORT.

Blackley, Carl, 247 Washburn.
Buck, Champlin F., 49 Main.
*Hurd, S. W., 78 Main.
Pettit, Gaylord J., 13 East Ave.
Pettit, W. M., 32 Spaulding.
Watters, Fowler A., 29 Main.

MIDDLEPORT.

Robertson, Mrs. Helen M.

NIAGARA FALLS.

Gray, John, 1712 Main.
*Hodge, Wm. H., 8 Gluck Block.
Hodge, John W., 10 Gluck Block
*Hough, Walter D., 635 Main.

NORTH TONAWANDA.

Bentley, F. W.

ROYALTON.

Prish, W. J.

WILSON.

Draper, Wm. L.

ONEIDA COUNTY.

No Society.

CLAYVILLE.

Dewing, W. H.

BOONEVILLE.

Babcock, E. C.
‡Warren, W.

CLINTON.

‡Dever, I.

DEANSBORO.

Fairbank, Stuart J.

ROME.

‡Gifford, Alden,
*‡Scudder, N. C.
*‡Southwick, A. B.
‡Tousley, R. F., 203 W. Dominick.

TRENTON.

‡Spencer, R. S.

UTICA.

‡Capron, C. G., 236 Genesee.
‡Chase, C. E., 230 Genesee.
Cooper, C. G., 8 Carlisle Block.
‡Guile, E. B.
*‡Laird, F. F., 236 Genesee.
‡Moore, J. de V., Steuben Park.
*‡Terry, M. O., 196 Genesee.
*‡Watson, W. H., 270 Genesee.
‡Hennessy, Margaret E., 84 Second.

WATERVILLE.

*‡Dean, L. W.
Taft, F. P.

WHITESBORO.

*Haines, Charles T.

ONONDAGA COUNTY.

Annual Meeting, Syracuse, first Tuesday in May. President, W. C. DuBois; Vice-President, C. E. Hinman; Sec. and Treas., A. G. Anthony.

BALDWINSVILLE.

Heaton, Ely,
‡Martin, Alden.
‡Martin, Leslie.

ELBRIDGE.

‡Warren, Erastus.

FAYETTEVILLE.

Badgly, C.
Hutchinson, P.

JORDAN.

‡Warren, S. C.

LAFAYETTE.

‡Willer, A. M.

LIVERPOOL.

‡Young, J. R.

MEMPHIS.

‡Sullivan, N. B.

SKANEATELES.

*‡Cooper, C. S.

SYRACUSE.

‡Anthony, A. G., 608 S. Warren.
*Baldwin, G. E., 500 University Ave.
‡Brewster, A. J., 211 Shonnard.
*‡Candee, J. W., 501 Fayette Pk.
†‡Chaffee, R. W., 1701 W. Genesee.
*Church, Herbert A., 601 Warren
‡Crowell, L. C., 310 East Fayette.
‡Dake, Mrs. Addie B., 117 E. Jefferson.
*‡Du Bois, Willard C., 519 South Salina.
‡Emens, Harriet D., 321 Montgomery.
‡Flint, E. H., 1624 West Genesee.
*‡Gridley, Geo. L., 605 Warren.
‡Hale, C. D., 311 Warren.
*‡Hartman, W. L., 601 Warren.
‡Hinman, C. E., 8 Holland St.
‡Hooker, Frederick, 117 Kirk Block.
*‡Hoyt, Gordon W. 808 Madison
†‡Keeler, E. E., 452 Salina.
*‡Keese, J. M., 211 Shonnard.
*‡Kinne, A. B., Fayette Pk.
*‡Kinne, E. O., 311 Warren.
‡Leggett, Mrs. S. L. Guild, 329 James.
†‡Lukens, C. M., 117 E. Jefferson.
‡Putnam, F. B., 310 East Fayette.
‡Schumacher, Carl, 834 Butternut
*‡Sheldon, J. W., 501 Fayette Pk.
‡Sherwood, B. W., 1117 South Salina.

TULLY.

‡Barker, G. E.
*Leonard, Wm. H.

WARNER'S.

‡Houston, S. W.

ONTARIO COUNTY.

Annual Meeting, Canandaigua, second Wednesday in October, Prest. J. C. Knapp; Vice Prest., C. A. Rowley; Sec. and Treas., C. T. Mitchel.

CANANDAIGUA.

†‡Mitchel, C. T., 2 Park Pl.
*‡Warner, F. P.

CLIFTON SPRINGS.

*‡Foster, Henry.
Boynton, ——.

EAST BLOOMFIELD.

*‡Partridge, Barton S.

GENEVA.

*‡Covert, N. B.
*Hopkins, W. W
*‡Knapp, James C.
McKenzie, J. E.
‡Stebbins, J. H.

NAPLES.

Conley, D. C.

OAKS CORNERS.

*‡Church, G. H., (Lic.)

PHELPS.

‡Pritchard, G. C.

PORT GIBSON.

*Throop, A. P.

SHORTSVILLE.

‡Cooke, J. D.

VICTOR.

*‡Rowley, C. A.

ORANGE COUNTY.

No Society.

GOSHEN.

McGeoch, R. L.
*Seward, F. W.

MIDDLETOWN.

*Ashley, Maurice C.
*Barrus, Clara.
Bradner, Julia A.
Emery, Wm. G.
Everett, Edward A.
*Fancher, E., 16 Orchard.
*Francisco, David E.
Hanmer, J. La T., 6 Low Block.
*Kinney, C. Spencer.
*Powelson, Arthur P.
Powelson, Howard J.
Schulz, E. M.
*Talcott, Selden H.
Turner, Reeve.
Woodman, R. C.

NEWBURGH.

Beattie, Mary E., 118 Grand.
Brink, Wm. H., Grand Avenue.
*Jacobson, F. A., 269 Grand.
Manbey, J. A., 233 Liberty.
Mitchell, Geo. B. I., 116 Liberty.
*Mitchell, J. J., 242 Montgomery.
Snyder, W. H., 130 Third.

PORT JERVIS.

*Best, Fred'k W.
Lambert, E. B.

SLATE HILL.

Carpenter, A. J.

WALDEN.

Faulkner, W. H.

WARWICK.

Cummins, Frank M.
Cummins, J. Seeley.

WASHINGTONVILLE.

Reed, Wm. E.

ORLEANS COUNTY.

No Society.

ALBION.

Carrier, E. K.
Hoye, Mrs. S. V.
Norton, F. R.
Stough, C. F.

CLARENDON.

Conklin, R. C.

MEDINA.

*Gillette, Myra A.
Scott, F. W.
*Swett, Emily F.

OSWEGO COUNTY.

Annual Meeting, Owego, second Tuesday in June. Prest., W. L. Woodbury; Vice-Prest., N. H. Haviland; Necrologist, Sec. and Treas., L. B. Richards.

FULTON.

‡Woodbury, W. L.
‡Haviland, N. H.

MEXICO.

*‡Radway, C. W.
‡Stow, T. D.

OSWEGO.

Albertson, C. S., 9 W. Bridge.
Calisch, A. C., 55 West Bridge
*‡Hinman, E. L., 84 West Oneida.
‡‡Richards, L. B., E. Bridge and Second.

PALERMO.

‡Woodruff, M. R., (Lic.)

PHOENIX.

Young, Daniel F.

WILLIAMSTOWN.

Ball, G. R.

OTSEGO COUNTY.

No Society.

COOPERSTOWN.

Blodgett, T. S.
Harrison, H. A.

HARTWICK.

Luce, Daniel

MORRIS.

Matison, Merritt

ONEONTA.

*Getman, A. D.

OTSEGO.

Cossart, James

RICHFIELD SPRINGS.

Getman, Norman

UNADILLA.

Clark, P. G.

PUTNAM COUNTY.

(‡*Westchester County Society.*)

BREWSTER.

Newman, L. G.
*Brinkman, Mrs. M. A.

PATTERSON.

*Birdsall, Thomas P.

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